

Vernick and Gopal, LLC  
1244 Boylston St, Suite 303  
Chestnut Hill, MA 02467  
Tel 617-383-6800 Fax 617-383-6801

Date: \_\_\_\_\_

New Patient Registration Form

Acct# \_\_\_\_\_

**Demographics:**

Patient's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Social Security # (SSN): \_\_\_\_\_ Male  Female

Street Address: \_\_\_\_\_ Apt #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Mobile/Other: Phone: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

Marital Status:  Married  Divorced  Single Email: \_\_\_\_\_

Emergency Contact: Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Best contact telephone#: \_\_\_\_\_

**Insurance Information:**

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_

Membership ID# \_\_\_\_\_ Membership ID# \_\_\_\_\_

Carrier's Name and DOB: \_\_\_\_\_ Carrier's Name and DOB: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

**Referral Information:**

*Who referred you to our office today? How did you hear about our practice?*

**Primary Care Physician:**

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Telephone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

*Please list names of any ADDITIONAL PHYSICIANS that should receive notes from our office*

1. Name: \_\_\_\_\_ Address: \_\_\_\_\_

Telephone \_\_\_\_\_ Specialty: \_\_\_\_\_

2. Name: \_\_\_\_\_ Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Specialty: \_\_\_\_\_

Acct# \_\_\_\_\_

### Background Information

Please check as appropriate.

#### Federal Government Information Requirement

Preferred Language:  English  French  Japanese  Spanish  Chinese  Other \_\_\_\_\_

Patient Race:  American Indian or Alaska Native  Asian  Black or African American

Native Hawaiian or other Pacific Islander  Caucasian/White  Other/Unspecified

Patient Ethnicity:  Hispanic or Latino  Not Hispanic or Latino  Other/Unspecified

### Social History

Alcohol Use:  Never  Moderate  Occasionally  Social # Drinks per week: \_\_\_\_\_

Exercise Regularly:  Yes  No

Exposure to Fumes, Dust, Solvents or Airborne Particles:  Yes  No  none known

Recreational Drug Use:  Never  Former  Current

Smoking History:  Current Every Day  Current Some Days  Former Smoker  Never Smoker

# Of Years of Active Smoking: \_\_\_\_\_ Years since quitting: \_\_\_\_\_

Other Tobacco Use? (Pipe, Cigars, Chew): \_\_\_\_\_

### Pharmacy Information

Local Pharmacy Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Mail Order Pharmacy Name: \_\_\_\_\_ Mail Order ID: \_\_\_\_\_

Telephone # \_\_\_\_\_ Fax #: \_\_\_\_\_

Pharmacy Preference (please choose) Local Pharmacy:  Mail Order:

Reason for TODAY's visit: \_\_\_\_\_

Acct # \_\_\_\_\_

**Surgical History**

Have you had a tonsillectomy? Yes No Year: \_\_\_\_\_

Cancer: Specify \_\_\_\_\_

Cardiac: Specify \_\_\_\_\_

Cosmetic: Specify \_\_\_\_\_

Ear Surgery: Specify \_\_\_\_\_

Nose Surgery: Specify \_\_\_\_\_

Throat Surgery: Specify \_\_\_\_\_

Other Surgery: \_\_\_\_\_

**Family History**

Illness/Condition	Father	Mother	Brother	Sister
<b>Family History Unknown:</b> Check box				
Abdominal Aortic Aneurysm				
Alzheimer's Disease				
Behavioral/Emotional Health				
Bleeding Disorders				
Brain/Nervous System				
Cancer				
Diabetes				
Hearing Loss				
Heart/Cardiovascular				
Genetic Disorders				
Migraines				
Respiratory Disorders				
Stroke				

Have you ever had a pneumonia immunization? Please circle one: Yes No Unknown

Acct # \_\_\_\_\_

**Past Medical History**

(Check the box to the left of the condition that you are currently being treated for or have been treated for in the past)

<input type="checkbox"/>	Allergies (Seasonal/Environment)	<input type="checkbox"/>	Deep Vein Thrombosis (DVT)	<input type="checkbox"/>	Low Blood Pressure
<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Depression	<input type="checkbox"/>	Lupus
<input type="checkbox"/>	Angina	<input type="checkbox"/>	Dermatologic (Skin)Disease	<input type="checkbox"/>	Lyme Disease
<input type="checkbox"/>	Acid Reflux	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Lymphoma
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Diverticulosis	<input type="checkbox"/>	Melanoma
<input type="checkbox"/>	Atrial Fibrillation	<input type="checkbox"/>	Eye Disease	<input type="checkbox"/>	Mitral Valve Prolapse
<input type="checkbox"/>	Auto-Immune Disease	<input type="checkbox"/>	Gallbladder Problems	<input type="checkbox"/>	Myocardial Infarction
<input type="checkbox"/>	Behavioral Disorder	<input type="checkbox"/>	Gastrointestinal/GI Problems	<input type="checkbox"/>	Neurological Problems
<input type="checkbox"/>	Bleeding Disorder	<input type="checkbox"/>	GERD/Reflux	<input type="checkbox"/>	Neuropathy
<input type="checkbox"/>	Blood Clots	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	Pneumonia
<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Head Injuries	<input type="checkbox"/>	Renal Disease
<input type="checkbox"/>	Chronic Fatigue Syndrome	<input type="checkbox"/>	Headaches (migraine, cluster)	<input type="checkbox"/>	Rhinitis
<input type="checkbox"/>	Cardiovascular (Heart Disease)	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	Seizure Disorder
<input type="checkbox"/>	Chronic Heart Failure (CHF)	<input type="checkbox"/>	High Blood Pressure (Hypertension)	<input type="checkbox"/>	Sinus Problems/Sinusitis
<input type="checkbox"/>	Congenital Heart Disease	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	Transient Ischemic Attack (TIAs)
<input type="checkbox"/>	COPD/Emphysema	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	Thyroid Disease
<input type="checkbox"/>	Coronary Heart Disease	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	Crohns Disease	<input type="checkbox"/>	Kidney/Urinary Bladder Problems	<input type="checkbox"/>	Ulcers (other)
<input type="checkbox"/>	Cerebral Vascular Accident (CVA)	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	Ulcers (stomach)

None of the above applies:  check here

**Review of Symptoms (ROS):**

Identify which if any of the following you are currently experiencing:

<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	Frequent Nose Bleeds	<input type="checkbox"/>	Rash
<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	Headache	<input type="checkbox"/>	Shortness of Breath
<input type="checkbox"/>	Cough	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	Skin Lesions
<input type="checkbox"/>	Depression	<input type="checkbox"/>	Hoarseness	<input type="checkbox"/>	Sore throat
<input type="checkbox"/>	Difficulty Hearing	<input type="checkbox"/>	Joint/Muscle Pain	<input type="checkbox"/>	Vision changes
<input type="checkbox"/>	Difficulty Sleeping	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	Weight gain/loss
<input type="checkbox"/>	Difficulty Swallowing	<input type="checkbox"/>	Noises in Ear/Head	<input type="checkbox"/>	Wheezing
<input type="checkbox"/>	Fainting	<input type="checkbox"/>	Pregnant	<input type="checkbox"/>	

Other Symptom(s) Not Listed: \_\_\_\_\_

\_\_\_\_\_

Acct # \_\_\_\_\_

### Medication History

Please list all medications that you're taking including over-the-counter medications, vitamins and other treatments. Please attach your medication list if more convenient.

Name of Medication Include over the counter medications	Dosage (mg/units/puffs/drops)

Patient reviewed and acknowledges that they are not taking any medications at this time:  check here

**Drug, Food and Latex Allergies**

**Drug Allergies:**  No  Yes

If yes, please list Drug name and reaction:

Drug Name: \_\_\_\_\_ Reaction: \_\_\_\_\_

Drug Name: \_\_\_\_\_ Reaction: \_\_\_\_\_

Drug Name: \_\_\_\_\_ Reaction: \_\_\_\_\_

**Latex Allergy:**  No  Yes Reaction: \_\_\_\_\_

**Shellfish Allergy:** Yes  No

**Other Food Allergies:** \_\_\_\_\_

### Patient/Physician Acknowledgement Signatures

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Nasal Obstruction Symptom Evaluation (NOSE) Score

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Email \_\_\_\_\_

Please help us better understand the impact of nasal obstruction on your quality of life by completing the survey below.

Over the past **4 weeks**, how much of a **problem** were the following symptoms for you?

Please mark the most correct response

	<i>Not a Problem</i>	<i>Mild Problem</i>	<i>Moderate Problem</i>	<i>Significant Problem</i>	<i>Severe Problem</i>
Nasal Congestion or Stuffiness	0	1	2	3	4
Nasal Blockage or Obstruction	0	1	2	3	4
Trouble Breathing Through My Nose	0	1	2	3	4
Trouble Sleeping	0	1	2	3	4
Unable to Get Enough Air Through My Nose During Exercise or Exertion	0	1	2	3	4

Significant and Severe Obstruction may indicate a narrow nasal airway. Ask your doctor about a non-surgical procedure that may provide you lasting relief for your stuffy nose.

## Office Administration

Sum the answers the patient marked and multiply by 5 to base scale out of a possible score of 100 for analysis.

<b>Symptoms Total</b>	_____
<b>Multiply total by 5 and enter below.</b>	
<b>Patient's N.O.S.E. Score</b>	_____

<b>0</b>	<b>No Obstruction</b>
<b>5-25</b>	<b>Mild Obstruction</b>
<b>26-50</b>	<b>Moderate Obstruction</b>
<b>51-75</b>	<b>Significant Obstruction</b>
<b>76-100</b>	<b>Severe Obstruction</b>