

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
Family History Unknown: 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.

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

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