VERNICK & GOPAL
HEARING CENTER
1244 BOYLSTON ST. SUITE 303
CHESTNUT HILL, MA 02467
Office # 617-383-6830 Fax # 617-383-6880 **SSIMED#____________**

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:**____

Health Status: □ Hearing Impaired □ Visually Impaired □ Disabled

Emergency Contact/Nearest Relative Information:

Name: _____________________________________

Relationship: Spouse □ Brother □ Sister □ Daughter □ Son □ Parent □ Friend □ Other □ __________

Telephone or Cell Phone (best way to reach): ______________________________________

Referral Information:

Primary Care Physician:

Name:_________________________________

Address: ________________________________

Telephone #: ______________________________

Fax #: __________________________________

Referring Physician:

Name: ___________________________________

Address: __________________________________

Telephone #: ________________________________

Fax #: ___________________________________

Insurance Information:

Primary Insurance: _______________________ Membership ID: ________________________________

Group #: ______________________________ Carrier's Name: ___________________________________

Carrier's DOB: ________________________ Relationship to Patient: ____________________________

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Secondary Insurance: __________________ Membership ID: __________________________________

Group #: ______________________________ Carrier's Name: ___________________________________

Carrier's DOB: ________________________ Relationship to Patient: ____________________________

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NEW PATIENT REGISTRATION FORM

Name:______________________________**DOB:**____________

Primary Care Physician:______________________**Occupation:**______________________

I. Primary Symptom (s):____

____

II. Present Symptoms and Hearing Complaints:

Hearing Loss: Both Ears Right Only Left Only N/A

When did your hearing loss first begin?____

Do you know what caused your hearing loss?______________________________________

Has your hearing changed? (i.e. sudden, gradual, fluctuating)____________________________

Do you have a better hearing ear?____

Tinnitus (Noise in ears): Both Ears Right Only Left Only N/A

Describe the sound:____

When did it first occur?____

Is the sound constant or periodic?____

If periodic, how often does it occur?____

Is the sound distressing to you? If yes, describe:___________________________________

Feeling of Fullness: Both Ears Right Only Left Only N/A

When did the fullness first occur?____

Constant or periodic?____

If periodic, how often does it occur?____

 Revised 7/2015

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Dizziness/Unsteadiness: _____ None

Describe the symptom(s):____

When did it first occur?____

Constant or periodic?____

If periodic, how long does it last?_______________________________________

Noise History:

Do you have military experience?

YES NO

Have you been exposed to noise in the past 14 hours?

YES NO

If yes, did you wear hearing protection during the entire noise exposure?

YES NO

When in high noise areas, I use hearing protection: 0% 20% 40% 60% 80% 100%

Type of hearing protection used ____

Have you ever participated in any of the following? Circle all that apply.

Chain saw | Dirt bike or loud RV | Firearms | Loud Music
Lawn Equipment | Wood working equipment | Other Noise Exposure____________

Hearing Aids: Both Ears Right Only Left Only N/A

Make:____

Model:____

Style:____

Year:____

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Ear Infections/Middle Ear Problems: Both Ears Right Only Left Only N/A

Describe condition(s):____

Previous treatment(s):____

III. In the past 90 days have you experienced:

Ear Pain:	Both Ears	Right Only	Left Only	N/A
Ear Discharge:	Both Ears	Right Only	Left Only	N/A
Sudden Change in Hearing:	Both Ears	Right Only	Left Only	N/A

IV. Have you seen a physician or ear specialist in the last six months?

YES NO

Doctor's Names:____

____

V. Have you ever had any of the following physical conditions? Circle Yes or No and describe.

Middle Ear Infections____________________	YES	NO
Ear Surgery____________________	YES	NO
Ear Malformations____________________	YES	NO
Vision Loss____________________	YES	NO
Cleft Palate____________________	YES	NO
Heart Defect____________________	YES	NO
Kidney disease or infection____________________	YES	NO

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Arthritis________________	YES	NO
Diabetes________________	YES	NO
Bones that break easily________________	YES	NO
Learning impairment________________	YES	NO
High blood pressure________________	YES	NO
Head injury/unconsciousness________________	YES	NO
Mumps________________	YES	NO
Scarlet Fever________________	YES	NO
Measles________________	YES	NO
Meningitis________________	YES	NO
Allergies________________	YES	NO
Chemo/Radiation________________	YES	NO

VI. Family History of Hearing Loss:________________________________

____

____

VII. Please list all medications you are currently taking and allergies: (See attached Medication Form)

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Medication Form

Patient's Name: ______________________________

D.O.B. ____________________

Date of Service: ____________________

Drug / Medication Information

List all medications you are currently taking: Include prescription drugs, inhalers, aspirin products, non-steroidal anti-inflammatories, eye drops, herbal supplements, nutritional supplements, vitamins, over-the-counter medications and non-prescription drugs.

Medication/Drug Name	Dose	Frequency	When You Last Took Medication

Please list any known allergies:

____

____

____

Revised 7/2015