GAVIN AUDIOLOGY AND HEARING AIDS

Tax ID# 812791226

Dr. Sharon K. Gavin, Au.D. Tax ID# 134401319 200 South Broadway Tarrytown, NY 10591

Patient Name:________________________________ **Sex:** _____ **DOB:** __________ **Age:** _____

First Middle Initial Last

Mailing Address: ____

Street City State Zip

Preferred Phone #: ________________ **Cell #:** ________________**Home/Work/Other #:** __________

Email Address: __________________________ May we contact you via email? ◯ Yes ◯ No

Pt. Social Security #: ________________ **Occupation (previous if retired):** ________________

PRIMARY Medical Insurance: ________________ Insurance ID#: ________________

Referral Required?:________________ Copayment:________________

Policy Holder:________________ Policy Holder DOB:________________

SECONDARY Insurance:________________ Insurance ID#:________________

Policy Holder:________________ Policy Holder DOB:________________

Disclaimer: As a professional courtesy, we will submit your claim to your insurance provider, but this does not guarantee their payment. You accept responsibility for copayment, deductibles or uncovered procedures. Your insurance must be on file at the time of your appointment.

I hereby authorize Gavin Audiology and Hearing Aids to release any medical or other information to my insurance carrier necessary to process my claim and I hereby assign all payment of authorize benefits be made on my behalf to Gavin Audiology and Hearing Aids.

I understand that if I am seen without a referral from my primary care physician and if my health plan requires that I obtain that referral, then my health plan may not cover the changes, costs or expense of my care from Gavin Audiology and Hearing Aids and in that case, I will be responsible for the total balance. Privacy Practice Notice: According to government law, we are required to make available to you a copy of our privacy practice notice. Your signature below acknowledges your receipt of this notice. **PLEASE INITIAL:** ____________

Primary Care Physician Full Name: ____________________ **Phone Number:** ____________

Fax Number: ____________

Address: ______________ City: ________State: _____ Zip code: _____

Current Medications (Prescription, OTC, herbals/vitamins/supplements)

Medication:____________ For:________ Since:________ Dose/Freq/Route:________

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Medication: ____________ For:________ Since:________ Dose/Freq/Route:________

Please check any of the following that you currently have or have had in the past:

◯ Pacemaker	◯ Vision Loss	◯ Peripheral Neuropathy	◯ Diabetes	◯ Stroke/TIA
◯ Measles/Mumps	◯ Ear Infections	◯ High Blood Pressure	◯ Ear Trauma	◯ Head Injury
◯ Depression	◯ Multiple Sclerosis	◯ Parkinson's Disease	◯ Dementia	◯ Cancer
◯ Ear Surgery	◯ Heart Condition	◯ Neurological Disorders	◯ Migraines	◯ MRI/CT scan

Patient Name: ________________**Patient Signature:** ________________**Date:** __________