



**GAVIN AUDIOLOGY**

AND

**HEARING AIDS**

Tax ID# 812791226

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

Once the form is filled out, please email: [drgavin@gavinhearing.com](mailto:drgavin@gavinhearing.com)

**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: \_\_\_\_\_

**Primary Care Physician: (PLEASE PRINT CLEARLY IN BLOCK LETTERS) Name:** \_\_\_\_\_ , \_\_\_\_\_  
Last First

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip code:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_ **Fax Number:** \_\_\_\_\_

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

Medication: \_\_\_\_\_ For: \_\_\_\_\_ Since: \_\_\_\_\_

Medication: \_\_\_\_\_ For: \_\_\_\_\_ Since: \_\_\_\_\_

Medication: \_\_\_\_\_ For: \_\_\_\_\_ Since: \_\_\_\_\_

Medication: \_\_\_\_\_ For: \_\_\_\_\_ Since: \_\_\_\_\_

Medication: \_\_\_\_\_ For: \_\_\_\_\_ Since: \_\_\_\_\_

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

- |                                     |                                          |                                              |                                  |                                   |
|-------------------------------------|------------------------------------------|----------------------------------------------|----------------------------------|-----------------------------------|
| <input type="radio"/> Pacemaker     | <input type="radio"/> Vision Loss        | <input type="radio"/> Peripheral Neuropathy  | <input type="radio"/> Diabetes   | <input type="radio"/> Stroke/TIA  |
| <input type="radio"/> Measles/Mumps | <input type="radio"/> Ear Infections     | <input type="radio"/> High Blood Pressure    | <input type="radio"/> Ear Trauma | <input type="radio"/> Head Injury |
| <input type="radio"/> Depression    | <input type="radio"/> Multiple Sclerosis | <input type="radio"/> Parkinson's Disease    | <input type="radio"/> Dementia   | <input type="radio"/> Cancer      |
| <input type="radio"/> Ear Surgery   | <input type="radio"/> Heart Condition    | <input type="radio"/> Neurological Disorders | <input type="radio"/> Migraines  | <input type="radio"/> MRI/CT scan |

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.

**PATIENT NAME:** \_\_\_\_\_ **PATIENT SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_