GAVIN AUDIOLOGY AND HEARINGAIDS

Tax ID# 812791226

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

Once the form is **completely** filled out, please email to: **drgavin@gavinhearing.com**

PLEASE PRINT

Patient Name:_____ **Sex:** _____ **DOB:** _____ **Age:** _____
First Middle Initial Last

Mailing Address: _____
Street City State Zip

Cell Phone #: _____ **Home #:** _____ **Preferred:** _____

Emergency Contact:_____**Relationship:**_____**Phone#:**_____

EMAIL ADDRESS: _____ May we contact you via email? ◯ Yes ◯ No

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 (NOT PHYSICIAN ASSISTANT) : (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:_____

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

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 information 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:** _____