

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

**Home Phone #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Cell #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Work/Other #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Email Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May we contact you via email? ⃝ Yes ⃝ No

**Preferred Method of Contact:** ⃝Home ⃝Cell ⃝Other ⃝Email ⃝Mail

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

**PRIMARY Insurance Company**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referral Required?:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Copayment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SECONDARY Insurance Company**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 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:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Fax Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Medication:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ For:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Since:\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose/Freq/Route:\_\_\_\_\_\_\_\_\_\_\_ Medication:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ For:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Since:\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose/Freq/Route:\_\_\_\_\_\_\_\_\_\_ Medication:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ For:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Since:\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose/Freq/Route:\_\_\_\_\_\_\_\_\_\_\_ Medication:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ For:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Since:\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose/Freq/Route:\_\_\_\_\_\_\_\_\_\_\_

Medication:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ For:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Since:\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose/Freq/Route:\_\_\_\_\_\_\_\_\_\_\_

By visiting Gavin Audiology, I voluntarily assume all risks related to exposure to COVID-19. **PLEASE INITIAL:\_\_\_\_\_\_\_\_\_\_\_\_**

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