Michael Wein M.D.

www.Michaelwein.com

PATIENT NAME: Date:

Briefly, the main reason for my visit is:

Tell us more about the problem

When did it start:

How frequent is it:

How has it progressed:

What makes it worse:

What makes it better:

Which doctors evaluated it:

Which meds have you tried:

What treatments tried:

What lab tests have you had:

What X-rays have you had:

ANYTHING ELSE YOU WANT US TO KNOW:

How did you hear about our office? Google Physician Referral Friend Other:

Has any member of your family been treated by us before? Name:

PLEASE CIRCLE THE CORRECT ANSWERS SO WE CAN LEARN MORE ABOUT YOU:

Drinking: DAILY WEEKLY RARELY

Smoking: ☐YES ☐NEVER ☐FORMER SMOKER What years did you smoke?

Have you ever had allergy testing? ☐YES ☐NO Or had allergy injections? ☐YES ☐NO

Current height: Weight: Pets: Dog Cat Other:

Current school or occupation (If retired, previous occupation):

What are your hobbies, how do you spend your time:

Years you have lived in Florida Where outside of Florida have you lived

Live Alone ☐YES ☐NO I live with

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MEDICAL HISTORY

Name of Primary Care Doctor: _____

Local Pharmacy (Name **and** Address): _____

Allergies to Medications: _____

Food Allergies: _____

Mail Away Pharmacy: _____ Account Number: _____

OTHER MEDICAL PROBLEMS (Check and comment below)

☐ Anxiety ☐ Asthma ☐ Eczema ☐ Blood Pressure ☐ Diabetes ☐ Glaucoma ☐ Thyroid

☐ Heart Disease ☐ Hearing Loss ☐ Depression ☐ Sleep Apnea ☐ Cancer

PLEASE LIST ANY OTHERS

_____

_____

_____

VACCINATION HISTORY

COVID Vaccine: _____ Date: _____

Pneumonia Vaccine: _____ Date: _____

PREVIOUS SURGERY – Reason/dates Please include: Ear Tubes; Nasal/Sinus; Tonsils/Adenoids

_____ _____

_____ _____

_____ _____

HOSPITAL OR EMERGENCY ROOM VISITS – **Reason and Dates**

_____ _____

_____ _____

_____ _____

FAMILY HISTORY (Please Check): Mother: ☐ Alive ☐ Deceased Father: ☐ Alive ☐ Deceased

MOM: ☐ Asthma ☐ Blood Pressure ☐ Diabetes ☐ Stroke ☐ Heart Disease ☐ Eczema ☐ Cancer (What kind _____)

DAD: ☐ Asthma ☐ Blood Pressure ☐ Diabetes ☐ Stroke ☐ Heart Disease ☐ Eczema ☐ Cancer (What kind _____)

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PATIENT NAME: _____

REVIEW OF SYSTEMS – Circle if you have had in the past month

GENL: ☐ Fever ☐ Weight Loss ☐ Fatigue

EYE: ☐ Itchy Eyes ☐ Blurred Vision

ENT: ☐ Hoarseness ☐ Loss of Smell ☐ Snoring

CARDIAC: ☐ Chest Pain ☐ Palpitations

GASTRO: ☐ Nausea ☐ Vomiting ☐ Heartburn ☐ Diarrhea

URINARY: ☐ Difficulty Urinating ☐ Painful Urination

SKELETAL: ☐ Joint pain ☐ Joint swelling

SKIN: ☐ Eczema Hives Itching ☐ Sores in Mouth Rash

NEURO: ☐ Headaches ☐ Migraine ☐ Numbness

BLOOD: ☐ Nose Bleed ☐ Swollen Glands

IMMUNE: ☐ Frequent Infections ☐ Node Swelling

LUNG: ☐ Cough ☐ Shortness of Breath ☐ Wheezing

PSYCH ☐ Depression ☐ Anxiety

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Patient Name: _____ _____ _____ Today's Date: _____
Last First Middle initial

*Date of Birth: _____ *Sex ☐ M ☐ F Social Security Number: _____

_____ _____
Street Address City, State, Zip code

_____ _____ _____
Home Phone Work Phone Cell Phone

*Email: _____ PCP: _____ REFERED FROM: _____

_____ _____
Emergency Contact Contact Number

Do you have a DNR? ☐ Yes or ☐ No If yes, please attach a copy.

Please provide the following information to better treat medical conditions, which may be related to these items and to ensure communication is clear.

*1. Race: _____
*2. Ethnicity (circle one): ☐ Hispanic or ☐ Non-Hispanic
*3. Preferred Language: _____

Primary Insurance

_____
Insurance Carrier

_____ _____
Identification Number Group Number

_____ _____
Subscriber Name Subscriber Date of Birth

Secondary Insurance

_____
Insurance Carrier

_____
Identification Number Group Number

_____ _____
Subscriber Name Subscriber Date of Birth

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ACKNOWLEDGMENT OF RESPONSIBILITY

No-Show or Late Cancellation of Appointments

Any patient that cancels less than 24 hours prior to their appointment or is a no show for their appointment will be charged a fee of $25.00.

Responsible Party Signature	Relationship	Date

Assignment of Benefits

If my current insurance policy prohibits direct payment to Dr. Michael Wein or mails payment directly to me, I will forfeit the payment check to the office of Dr. Michael Wein. If the payment check is not surrendered then the remaining balance for services rendered is my responsibility.

Responsible Party Signature	Relationship	Date

Financial Responsibility

I authorize the office of Michael Wein, M.D., P.A. to file my insurance claim and receive payments for treatment rendered**. I understand and accept full financial responsibility including any co-pays, deductibles, or percentages that my insurance does not cover.** I understand that if I do not have insurance coverage, payment is due at the time of service; unless other arrangements are made with this office.

I authorize Dr. Michael Wein, M.D., P.A. and staff to discuss or release my medical information with the family member/friend listed below. I understand I can revoke this authorization at any time. I understand I will still need to sign a records release for any written reports to be released to myself or another family member.

Patient/Responsible Party Signature	Relationship	Date

Family member/Friend to release information to	Contact Phone Number

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PROTECTED HEALTH INFORMATION CONSENT

I hereby give consent to the office of Dr. Michael Wein to use and disclose my protected health information for the purposes of treatment, payment and health care operations.

My protected health information consists of health information, including my demographic information, whether received by me, another physician or health care provider, insurance carrier, my employer or health care clearinghouse. This may also include prescription history information received by another physician or pharmacy. This protected health information relates to my past, present or future health/conditions(s).

Our Notice of Privacy Practices provides more detailed information about how we may use and disclose your protected health information. A copy out Notice of Privacy Practices is available upon request before signing this consent. Our practice reserves the right to change the terms of out Notice of Privacy Practices.

You may revoke this consent at any time. This must be in writing and signed by you or on your behalf.

Sign:_____ Date: _____

Print name of patient:

_____

If you are signing as the patient's representative:

Print your name:

_____

Relationship:

_____

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FORMULARY BENEFITS DATA CONSENT FORM

Formulary Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBM's are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

By signing below, I give permission for Michael Wein MD PA to access my pharmacy benefits data electronically through SureScripts. This consent may enable us to:

Download a historic list of all medication prescribed for a patient by any provider.

In summary, we ask your permission to obtain formulary information, and information about other prescriptions prescribed by other providers using SureScripts.

Patient Name (Printed)

Date of Birth

Signature of Patient or

Legal Guardian (If patient is under 18 years)

Date

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Current Medications List

Name: _____

Prescription Medications:

Name of Medication	Strength	FREQUENCY	CONDITION	PHYSICIAN

Please remember to include all: ASTHMA INHALERS, NOSE SPRAYS, TOPICAL CREAMS

Please list all your current physicians and their area of specialty 1_____ 2_____ 3_____

Supplemental questions for children:

Birth was: ☐ full-term, ☐ premature, ☐ spontaneous, ☐ vaginal, ☐ cesarean, ☐ induced

Feeding at birth was: ☐ breast-fed, ☐ bottle-fed

Immunizations: ☐ up to date, ☐ delayed

Growth and development: ☐ normal ☐ delayed

Family history of immune deficiency: ☐ yes ☐ no

Siblings: ☐ yes ☐ no

Asthma: ☐ yes ☐ no

Breathing problems: ☐ yes ☐ no

Skin problems: ☐ hives, ☐ rash, ☐ eczema, ☐ none

Smoking family: ☐ yes ☐ no

Hospitalizations: ☐ yes ☐ no

Day care: ☐ yes ☐ no

Attends school: ☐ yes ☐ no

Current diet includes: _____

MICHAEL WEIN M.D.

Family Allergy Asthma & Immunology

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

3375 20th Street, Suite 140, Vero Beach, FL 32960 ~ Phone 772.299.7299 ~Fax 772.563.9191
320-322 NW Bethany Drive, Port Saint Lucie, FL 34986 ~Phone 772.621.9992 ~Fax 772.563.9191

Patient Name: _____

Date of Birth: _____ **Cell Phone**: _____

Home Address: _____

_____

Specific Information to be Disclosed/Brief Description of PHI Disclosed: (check all that apply)

____Lab test results, specify: _____ ____Radiology test results, specify: _____

_____ _____

____Entire Medical Record ____Other, specify: _____

____IT: Injection log, vial contents, skin test results, _____

most recent office notes _____

Dates of Service requested: _____

Recipient: Name of the person(s) to whom MICHAEL WEIN, MD may obtain my health information:

_____

_____

Term: This Authorization will remain in effect:

____From the date of this Authorization until_____.

_____ _____

Signature of Patient Date

If the patient is a minor or otherwise unable to sign this authorization, obtain the following signature:

_____

Signature of Personal Representative

_____ _____

Description of Authority (guardian, healthcare proxy etc.) Date