

Michael Wein M.D.

Family Allergy Asthma Immunology

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: _____

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.

Patient/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.

Patient/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.

Family member/Friend to release information to

Contact Phone Number

Patient/Responsible Party Signature

Relationship

Date

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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 our 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.

Patient/Responsible Party Signature	Relationship	Date
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Patient/Responsible Party Print Name

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/Responsible Party Signature	Relationship	Date
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Patient/Responsible Party Print Name

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PATIENT NAME: _____ **DOB:** _____

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: _____

Do you have medical records with you? **YES – NO**

If yes, please give to front desk staff to scan into your chart.

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

Drinking: ☐ DAILY ☐ WEEKLY ☐ RARELY ☐ NEVER

Smoking: ☐ NEVER ☐ CURRENT ☐ FORMER ☐

Have you ever had allergy testing? YES ☐ NO ☐

Height: _____ in. Weight: _____ lbs.

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 _____

What years did you smoke? _____

Or had allergy injections? YES ☐ NO ☐

Pets: Dog Cat Other: _____

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PATIENT NAME: _____ DOB: _____

Name of Primary Care Doctor: _____

Medication Allergies: _____

Food Allergies: _____

Local Pharmacy (Name and Address): _____

Mail Away Pharmacy: _____ Account Number: _____

OTHER MEDICAL HISTORY (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

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): FATHER: ☐ Alive ☐ Deceased MOTHER: ☐ Alive ☐ Deceased

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

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

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PATIENT NAME: _____ DOB: _____

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
URINARY:	☐ Difficulty Urinating	☐ Painful Urination	
SKELETAL:	☐ Joint pain	☐ Joint swelling	☐
SKIN:	☐ Eczema	☐ Hives	☐ Itching
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: _____ DOB: _____

Current Medications List

Name of Medication	Strength	Frequency	Condition	Physician

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

Current physicians and specialty 1 _____ 2 _____ 3 _____

4 _____ 5 _____ 6 _____ 7 _____

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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

This document and any attachments may contain confidential and privileged information not intended for distribution or disclosure. The information may include patient information protected by federal and state law and is intended only for the recipient as indicated above. If you are not the intended recipient, please notify the sender immediately at 772.299.7299 and delete all copies. Distribution of this information is strictly prohibited.

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Additional Questions for Patient's 17 Years of Age or Younger:

☐ ☐ ☐ ☐ ☐ ☐

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

☐ ☐

Feeding at birth was: breast fed or bottle fed; if bottle fed, what formula: _____

☐ ☐

Immunizations: up-to-date or delayed

☐ ☐

Growth and development: normal or delayed; if delayed, please explain: _____

☐ ☐

Family history of immune deficiency: yes or no

☐ ☐

Siblings: yes or no

☐ ☐

Asthma: yes or no

☐ ☐

Breathing problems: yes or no

☐ ☐ ☐ ☐

Skin problems: hives, rash, eczema, none

☐ ☐

Smoking household: yes or no

☐ ☐

Hospitalizations: yes or no

☐ ☐

Daycare: yes or no

☐ ☐

Attends school: yes or no; if yes, what school: _____

Current diet includes: _____