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 Date

Legal Guardian (If patient is under 18 years)

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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 disclose 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.