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): _____

Medication Allergies: _____

Food Allergies: _____

Mail Away Pharmacy: _____ Account Number: _____

OTHER MEDICAL PROBLEMS (Circle and comment below)

Anxiety Asthma Eczema Blood Pressure Diabetes Glaucoma Heart Disease Hearing Loss Thyroid Depression Sleep Apnea PLEASE LIST ANY OTHERS

_____

_____

_____

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

_____ _____

_____ _____

_____ _____

HOSPITAL OR EMERGENCY ROOM VISITS – Reason and Dates

_____ _____

_____ _____

_____ _____

FAMILY HISTORY (Please circle): 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: _____