# 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 ofout 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

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 drugprograms 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 aboutother prescriptions prescribed by other providers using SureScripts.

Patient/Responsible Party Signature Relationship Date

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:** _____

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

Drinking: ☐ DAILY ☐ WEEKLY ☐ RARELY ☐ NEVER

Smoking: ☐ NEVER ☐ CURRENT ☐ FORMER What years did you smoke? _____

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

Height: _____in. Weight: _____lbs. 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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**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 ☐ 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:**_____**DOB**: _____

## Current Medications List

| Name of Medication | Strength | Frequency | Condition | Physician |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
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| | | | | |

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**: _____

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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_____.

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_____ _____

**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

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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: _____