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:

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: __________________

HOSPTIAL OR EMERGENCY ROOM VISITS – Reason and Dates

____ ____

____ ____

____ ____

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

____ ____

____ ____

____ ____

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

____

____

____

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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

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: ____ 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 and Frequency	Condition Medication Taken For	Physician Who Prescribed Med	Notes

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