MICHAEL WEIN, MD

Michaelwein.info

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:_____

_____
Emergency Contact Contact Number

Do you have a DNR? Yes or No If yes, please provide copy.

Please provide the following information to better treat medical conditions which may be related to these items and to ensure communication is clear. Please take a moment to answer each of these:

*1. Race:_____
*2. Ethnicity (please circle one) Hispanic or Non-Hispanic
*3. Preferred Language:_____

Primary Insurance

_____
Insurance Carrier

_____
Identification Number Group Number

_____
Subscriber Name

_____
Subscriber Date of Birth Subscriber Social Security Number

Secondary Insurance

_____
Insurance Carrier

_____
Identification Number Group Number

_____
Subscriber Name

_____
Subscriber Date of Birth Subscriber Social Security Number

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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 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 a 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/condition(s).

Our Notice of Privacy Practices provides more detailed information about how we may use and disclose your protected health information. A copy our 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.

Sign: _____ Date: _____

Print name of patient: _____

If you are signing as the patient's representative:

Print your name: _____
Relationship: _____

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Patient Medication List

Patient Name:_____ DOB:_____

Primary Care Doctor:_____

Local Pharmacy (Name and Location):_____

Pharmacy Phone Number:_____

Medication Allergies:_____

Mail away Pharmacy:_____ Account Number:_____

Medication Strength Times per day

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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Medical History

Name:_____ Date:_____

In a few words, the reason for my visit is:_____

_____

What aggravates the condition:

_____

What makes it better:

Any other information that will help us to improve the care we offer you?

_____

_____

_____

_____

Have you ever had allergy testing? ❍Yes ❍No Or had allergy injections? ❍Yes ❍No

1. Do you smoke? ❍Yes ❍No Are you: ❑Retired ❑Disabled
2. What is your current school or occupation? _____
3. If retired, what is your previous occupation? _____
4. What are your hobbies? _____
5. Years have you lived in Florida? _____
6. Where outside of Florida have you lived? _____
7. Foreign countries visited? _____
8. Do you live alone? ❍Y ❍N Who lives with you _____
9. Where did you go to school? _____
10. Do you have pets? ❍Yes ❍No ❍Dog ❍Cat ❍Others _____

COMMENTS _____

Name:_____ Date:_____

FAMILY HISTORY

Mother: ❍Asthma ❍Cancer ❍Blood pressure ❍Diabetes ❍Stroke ❍Heart disease ❍Mental Illness

Father: ❍Asthma ❍Cancer ❍Blood pressure ❍Diabetes ❍Stroke ❍Heart disease ❍Mental Illness

Other _____

MEDICAL HISTORY

Do you have history of: ❍Anxiety ❍Asthma ❍Cancer ❍Cholesterol ❍Blood pressure ❍Depression ❍Diabetes ❍Glaucoma ❍Heart disease ❍Heartburn ❍Hearing loss ❍Stroke ❍Thyroid

Hospital/Emergency Room Visits – Reason and Dates

1._____

2._____

3._____

4._____

Past Surgery – Reason and Dates

1._____

2._____

3._____

4._____

Other Medical Issues:_____

_____

_____

Review of Systems – Circle if you have had a symptom in the past month:

Shortness of Breath	Wheezing	Headache	Cough
Snoring	Itchy/Watery eyes	Skin Swelling	Fatigue
Fever	Rash	Nose Bleed	Depression
Lymph node swelling	Heartburn	Nausea	Hoarseness