Dr. Michael Wein, M.D., P.A.

Patient Name_____ Today's Date_____
Last, First Middle Initial

***Date of Birth_____*Sex_____ Social Security Number_____**

Street Address_____
Street City, State Zip Code

Home Phone_____ Work Phone_____Cell Phone_____

Place of Employment_____Email:_____

Emergency Contact Name and Phone Number_____

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

We request 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_____

ID Number_____ Group Number_____

Subscriber Name_____

Subscriber Date of Birth/Social Security #_____
DOB Social Security #

Secondary Insurance_____

ID Number_____ Group Number_____

Subscriber Name_____

Subscriber Date of Birth/Social Security #_____
DOB Social Security #

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 Signature Date

_____ _____
Family Member/Friend to release information to Contact Phone Number