KEVIN H. WEINER MD

BOARD CERTIFIED

PHYSICAL MEDICINE AND REHABILITATION

NEW PATIENT INFORMATION

Patients Name: _____Todays Date: _____

Home Address: _____

City, State, Zip Code: _____

Home Telephone: _____ Cell Phone: _____

Date of Birth: _____ SS#: _____

Emergency Contact: _____ Phone: _____

Email Address: _____

Primary Language: _____ Race: _____ Ethnicity: _____

INJUY INFORMATION

Date of Injury: _____ Time of Injury: _____

How did the injury occur: _____

_____

Have you had x-rays taken as a result of this injury? YES NO

If YES, where were they taken?

_____

AUTO INSURANCE INFORMATION

Insurance Company Name: _____

Insurance Company Address: _____

City, State, Zip: _____

Claim Number: _____ Policy Number: _____

Claim Adjuster Name and Phone Number: _____

ATTORNEY INFORMAION

Law Firm Name: _____

Attorney Name: _____ Attorney Phone Number:

_____

GUARANTOR EMPLOYER INFORMATION

Employer Name: _____

Employer address: _____

City, State, Zip: _____

Employer Phone #: _____

Employer contact person and phone number: _____

INSURANCE AUTHROPZATION AND ASSIGNMENT

_____ request that payment of authorized insurance company benefits be made to Kevin H. Weiner, M.D.

I authorize any holder of medical or other information about me to release the social security administration and health care financing administration or its intermediaries or carriers any information needed for this, or a related insurance company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to Kevin H. Weiner, M.D. I understand it is mandatory to notify the health care provider or any other party who may be responsible for paying for my treatment.

Signature: _____ Date: _____

Print Name: _____

Is this visit due to a

Job related injury? YES ____ NO_____

Car Accident? YES ____ NO_____

Medical Health Questionnaire

Patients Name: _____ Age: _____ Date of Birth: _____

Height: _____ Weight: _____ Right or Left-handed (please circle one)

Name of Primary Physician: _____ Office #: _____

Address: _____

Name of Referring Physician: _____ Office #: _____

Address: _____

Preferred Pharmacy: _____ Town: _____

PRIOR SIGNIFICANT MEDICAL ILLNESS (please circle)

Cancer	NO	YES	Hypertension	NO	YES
Diabetes	NO	YES	Stroke	NO	YES
Hepatitis	NO	YES	Tuberculosis	NO	YES
Heart Disease	NO	YES			

OPERATIONS (please circle)

Prior Surgery	NO	YES	Hypertension	NO	YES
Cataracts	NO	YES	Hysterectomy	NO	YES
Heart Surgery	NO	YES	Tonsils	NO	YES

Other Surgeries NO YES Please specify: _____

MEDICATIONS CURRENTLY TAKING

Prescription Drugs

Name: _____ Dose: _____

Name: _____ Dose: _____

Over the counter Medications

Name: _____ Dose: _____

Name: _____ Dose: _____

ALLERGIES AND SENSITIVITIES (please circle)

Aspirin		NO	YES		Penicillin	NO	YES
Codeine	NO	YES		Sulfur	NO	YES	
Iodine	NO	YES					

Other Antibiotics (list) _____

Any Food(s) _____

Other drugs (list) _____

SOCIAL HISTORY (please circle)

Single Married Divorced Widowed

Alcoholic Beverages: Never Rarely Moderately Frequently

Tobacco:	Cigarettes	NO	YES	Packs/Day: _____
	Cigar	NO	YES	
	Pipe	NO	YES	

Occupation: _____ Retired NO YES

FAMILY HISTORY (please circle)

Father Age: _____	Health Status	Living	Deceased
Mother Age: _____	Health Status	Living	Deceased
Sibling Age: _____	Health Status	Living	Deceased
Sibling Age: _____	Health Status	Living	Deceased
Sibling Age: _____	Health Status	Living	Deceased

FAMILY HISTORY (please circle)

Arthritis	NO	YES		Gout	NO	YES	
Bleeding Tendencies		NO	YES	Heart Disease		NO	YES
Cancer		NO	YES	High Blood Pressure		NO	YES
Convulsions	NO	YES		Stroke	NO	YES	
Diabetes	NO	YES		Tuberculosis	NO	YES	

MEDICAL HISTORY QUESTINNAIRE (Ros)

Do you have any problems in the following areas? (Check yes or no)

General	YES	NO		**GI/GU**	YES	NO
Fever	___	___		Vomiting	___	___
Fatigue		___	___	Bloody bowel movement		___
Weight loss or gain	___	___		Heartburn	___	___
Frequent colds	___	___		Loss of appetite	___	___
EYES				Difficulty W/ urine	___	___
Blurred vision		___	___	Blood in urine		
Double Vision		___	___	Frequent urination		___
Redness	___	___		Pain while urinating	___	___
Sandy or gritty feeling		___	___	**MUSCULOSKELETAL**		
Blind spots	___	___		Muscle pain	___	___
Floater		___	___	Joint pain/arthritis		___
Flashes		___	___	**INTEGUMENTARY**		
Lazy eye	___	___		Rash, bruise easily	___	___
Itching, burning	___	___		Breast Disease		___
Excess tearing		___	___	**NEUROGICAL**		
Glare/light sensitivity		___	___	Fainting		___
Eye pain	___	___		Frequent headaches		___
Chronic infection eye/lid	___	___		Seizures	___	___
ENT: EARS/NOSE/THROAT				PSYCHIATRICH		
Sinus infection		___	___	Depression		___
Cough	___	___		Anxiety	___	___
Trouble walking	___	___		Psychiatric problems		___
Hoarseness	___	___		**ENDOCRINE**		
Loss of hearing	___	___		Excessive thirst	___	___
Nose bleeds	___	___		Excessive sweating	___	___
HEART						
HEMATOLOGIC/LYMPHATIC						
Chest pain	___	___		Swollen glands	___	___
Irregular heart burn	___	___		**ALLERGIC/IMMUNOLOGIC**		
Pacemaker	___	___		Seasonal allergies	___	___
Heart murmur		___	___	Hay fever		___
Swollen feet/ankles	___	___		**OTHER**		

Leg cramps when walking	___	___	Pregnant	___	___
LUNGS			Menopausal	___	___
Wheezing/shortness of breath	___	___	Vaginal Bleeding		___
___					
Coughing up blood/phlegm	___	___	Breast lumps	___	___

Kevin H. Weiner

1. I acknowledge that I have been given a copy of the practices "HIPPA Privacy notice" which describes the practices obligation to ensure the privacy of any health information. The HIPPA Privacy Notice also describes how the practice may use and discuss any health information for treatment, payment, and health care options. I know that I have the right to review the practices HIPPA Privacy Notice and to ask questions about it. I understand that the practice is required to maintain the privacy of my health information in accordance with the terms of its HIPPA Privacy Notice.
2. I further acknowledge that the practice can change its HIPPA Privacy Notice in the future and that I can receive a copy of the practices current Privacy Notice at any time by contacting the office at (718) 442-4422.
3. I understand that I have the right to request that the practice restricts its uses and disclosures of my health information for treatment, payment, or health care operations. If my restrictions are accepted by the practice, these restrictions will be binding on the practice. I also understand that practice is not required to agree to any of my restrictions.

   I do not request or restrict on the practice's uses of disclosures of my health information for treatment, payment, or health care operations.

   _____ (Initial)
4. By Signing this form, I consent to the practices use and disclosure of my health information for treatment, payment, and health care operations. I understand that I have the right to revoke this consent at any time in writing, but if I do, my revocation will not have an effect on any actions the practice has already taken in reliance on this consent.

X_____

Signature of patient or patient representative Date

If this form is signed by a patient representative please complete the following:

Print the name of the patient's representative: _____

Describe the representative's authority to act for the patient _____

NOTE: YOU MAY REFUSE TO SIGN THIS CONSENT, HOWEVER, IF YOU DO REFUSE,

THE PRACTICE MAY REFUSE TO PROVIDE YOU WITH NON-EMERGENCY CARE.

Total Body Orthopedics & Rehabilitation
963 Post Ave.
Staten Island NY 10302
Telephone: 718-442-4422
Fax: 718-556-3025

12 Hudson Valley Professional Plaza
Newburgh, NY 12550
Telephone: 845-561-1581
Fax: 845-784-4540

PAIN MANAGEMENT AGREEMENT

The purpose of this agreement is to prevent misunderstanding about certain medicines you will be taking for pain management. This is to help both you and your doctor comply with the law regarding controlled pharmaceuticals.

I understand that this agreement is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor undertakes to treat me based on this agreement.

I understand that if I break this agreement, my doctor will stop prescribing pain control medications.

In this case, my doctor will taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug-dependence treatment program may be recommended.

I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.

I will not use any illegal controlled substances including marijuana, cocaine, etc..

I will not share, sell, or trade my medications with anyone.

I will not attempt to obtain any controlled medicines, including opioid pain medicines, controlled stimulants, or anti-anxiety medicines from any other Doctor. Breaking of this agreement will result in discharge from this practice.

I agree that refills of my prescriptions for pin medications will be made only at the time of my office visit or during regular office hours. No refill will be available during evenings or weekends.

Pharmacy Name: _____

Address and Phone Number: _____

_____

I agree to use the above pharmacy for filling prescriptions for ALL my medicines.

I authorize the doctor and my pharmacy to cooperate fully within any city, state, or federal law enforcement agency, including this states board of pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicine. I authorize my doctor to provide a copy of this agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

I agree that I will submit to a blood or urine test, if requested by my doctor's office to determine my compliance with my program of pain control medicine.

I agree that I will use my medicine at a rate no greater than the prescribed rate that use of my medicine at a greater rate will result in my being without medication for a period of time.

I will bring all unuse pain medicines to every office visit.

I agree to follow these guidelines that have been fully explained to me. All my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.

Date of this agreement: _____

Patient Name: _____

Patient Signature: _____

Physician Signature: _____

Witnessed by: _____

NEW YORK VEHICLE NO-FAULT INSURANCE LAW ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENT OCCURING ON AND AFTER 3/1/02)

I, _____ (Assignor) hereby assign to _____ (Assignee)
(Print Patient Name) (Print health care provider name)
All rights privileges and remedies to payment for health care services provider by assignee to which I am entitled under Article 51 (the no fault statue) of the insurance law.

The assignee hereby certifies that they have not received any payment from or on behalf of the assignor and shall not pursue payment directly from assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident, which occurred on _____, notwithstanding any other agreement to the contrary.
(Date of injury)

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMAION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWKINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OF AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATE CLAIM FOR EACH VIOLATION.

_____ _____

PRINT NAME OF PATIENT

SIGNATRUE OF PATIENT

DATE OF SIGNATURE

ADDRESS OF PATIENT

KEVIN H WEINER MD

SIGNATURE OF PROVIDER

963 POST AVE STATEN ISLAND NY 10302

PROVIDER ADDRESS

DATE OF SIGNATURE

NYS FORM NF-AOB(Rev 1/2004)