PRIVATE INSURANCE

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: ______________

PRIMARY INSURANCE INFORMATION

Name of Insurance Company: ____

Policy Holder: ___________________________ Date of Birth: _______________________

Identification Number: ____________________ Group Number: _____________________

Relationship to Patient: ____

SECONDARY INSURANCE INFORMATION

Name of Insurance Company: ____

Policy Holder: ___________________________ Date of Birth: _______________________

Identification Number: ____________________ Group Number: _____________________

Relationship to Patient: ____

PRIVATE INSURANCE

GUARANTOR EMPLOYER INFORMATION

Employer Name: ____

Employer Address: ____

Office Number: ____________________ Fax: ________________________

E-mail Address: ____

Contact Person: ____________________ 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

PRIVATE INSURANCE

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
Fever	___	___
Fatigue	___	___
Weight loss or gain	___	___
Frequent colds	___	___
EYES		
Blurred vision	___	___
Double Vision	___	___
Redness	___	___
Sandy or gritty feeling	___	___
Blind spots	___	___
Floater	___	___
Flashes	___	___
Lazy eye	___	___
Itching, burning	___	___
Excess tearing	___	___
Glare/light sensitivity	___	___
Eye pain	___	___
Chronic infection eye/lid	___	___
ENT: EARS/NOSE/THROAT		
Sinus infection	___	___
Cough	___	___
Trouble walking	___	___
Hoarseness	___	___
Loss of hearing	___	___
Nose bleeds	___	___
HEART		
Chest pain	___	___
Irregular heart burn	___	___
Pacemaker	___	___
Heart murmur	___	___
Swollen feet/ankles	___	___
Leg cramps when walking	___	___

GI/GU	YES	NO
Vomiting	___	___
Bloody bowel movement	___	___
Heartburn	___	___
Loss of appetite	___	___
Difficulty W/ urine	___	___
Blood in urine	___	___
Frequent urination	___	___
Pain while urinating	___	___
MUSCULOSKELETAL		
Muscle pain	___	___
Joint pain/arthritis	___	___
INTEGUMENTARY		
Rash, bruise easily	___	___
Breast Disease	___	___
NEUROGICAL		
Fainting	___	___
Frequent headaches	___	___
Seizures	___	___
PSYCHIATRICH		
Depression	___	___
Anxiety	___	___
Psychiatric problems	___	___
ENDOCRINE		
Excessive thirst	___	___
Excessive sweating	___	___
HEMATOLOGIC/LYMPHATIC		
Swollen glands	___	___
ALLERGIC/IMMUNOLOGIC		
Seasonal allergies	___	___
Hay fever	___	___
OTHER		
Pregnant	___	___

LUNGS

Wheezing/shortness of breath ___ ___ ___

Coughing up blood/phlegm ___ ___

Menopausal ___ ___

Vaginal Bleeding ___

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: _____________________________________