CARL B. WEISS M.D., P.C. **Patient History**

Patient Name:_________________________ **D.O.B.**____/_____/_____

Age: ________ **Height:** _____**Ft.** ______**in.** **Weight:** ______ **lbs.**

Primary Care Physician: ____

Current Problem

What is the reason for your visit today? ____________________________________

Date of Injury/onset of symptoms? ____________________________________

Where did the injury occur? (circle one) At Home At Work During Sports/Recreation

Car Accident At School Other If you chose "**other**", please specify: ____________________

____

Have you had any previous medical care for this condition? (circle one) YES or NO

If YES, please specify: ____

____

PAST MEDICAL HISTORY Please circle any condition that **YOU** currently have or have a history of. If none, circle NONE.

Diabetes Gout Hereditary Defects Arthritis Kidney Failure/Dialysis COPD

Heart Trouble Stroke Liver Disease/Hepatitis High Blood Pressure Convulsions Cancer

Pacemaker/Defibrillator **NONE** Other

Please explain any circled items, or if "other", please specify:____________________________

____

____

Infectious Diseases:

Do you have or ever had any of the following diseases? Please circle all items that apply, if none, circle "NONE".

HIV/AIDS MRSA HEPATITIS A HEPATITIS B HEPATITIS C TUBERCULOSIS

SEXUALLY TRANSMITTED DISEASES **NONE** OTHER

If **"OTHER"**, please specify: ____

____

ARE YOU OR COULD YOU POSSIBLY BE PREGNANT? (circle one) YES or NO

Date of Last menstrual period? ____________________________________

Patient Name:______________________________ **DOB:**____________________

ALLERGIES:
Please circle all items that you are allergic to. If none, please mark "NO KNOWN ALLERGIES".

Penicillin	Latex/Rubber	Sulfa	Tetanus	Iodine(by mouth)
Pain Remedies	Codeine	Herbs	Novocain	Iodine(Intravenous)
Narcotics	Vitamins	Aspirin	Antibiotics	Iodine(topical)
Metals	Shellfish/Seafood	Food Allergies	**NO KNOWN ALLERGIES**	

Other If you chose "**other**", please specify:______________________________

Current Medications
Please list all medications, vitamins and supplements you are currently taking.

Name of Medication	Dosage	Frequency	Name of Medication	Dosage	Frequency

Social History

Do you use tobacco? YES or NO If YES, how many packs per day? ______________________________

If you have quit smoking, when did you quit?______________________________

Do you currently use recreational drugs? (circle one) YES / NO

Do you drink alcoholic beverages? (circle one) YES / NO If **YES**, how many drinks and how often? ______________

Marital Status: (circle one) Single Married Divorced Widow/er Separated

Surgical History

Additional Information:

Procedure: ____________________Date:__________ ______________________________

Procedure: ____________________Date:__________ ______________________________

Procedure: ____________________Date:__________ ______________________________

Procedure: ____________________Date:__________ ______________________________

FAMILY MEDICAL HISTORY
If your **family history is unknown** please check here: __________

Please check all that apply:	Mother	Father	Brother	Sister	Children
Diabetes					
Lung Disease					
Back Problems					
Cancer					
Heart Disease					
Arthritis					

Patient Name:____ **DOB**_________________________

Review of Systems Please check all items that apply to YOUR current health.

General:
___Excessive Fatigue
___Weakness
___Exercise Intolerance
___Fever
___**NONE**

Musculoskeletal:
___Muscle Cramps
___ Stiffness/ Swelling Joint
___Walking Difficulty
___Joint Pain
___**NONE**

Hematologic:
___Bruise easily
___Prolonged Bleeding
___Anemia
___Phlebitis
___**NONE**

Eyes:
___ Glasses/Contacts
___Blurred Vision
___Double Vision
___Cataracts/Glaucoma
___Light Sensitivity
___**NONE**

Respiratory:
___Shortness of breath
___Sleep Apnea
___Chronic Cough
___Asthma/Wheezing
___Bronchitis/Pneumonia
___**NONE**

Skin/Breast:
___Breast Cancer
___ Itching/Rash
___Fibro Cystic Disease
___Hives
___Dermatitis/Dry Skin
___**NONE**

Endocrine:
___Weight gain
___Weight Loss
___Thyroid Disease
___Gout
___Liver Problems
___Diabetes
___Glandular/Hormone Problems
___**NONE**

Cardiovascular:
___High Blood Pressure
___Pulmonary Artery Disease
___Palpitations
___Blood Clots
___Chest Pain
___Extremity Swelling
___Heart attack
___**NONE**

Genitourinary:
___Painful Urination
___Frequent Urination
___Incontinence
___Kidney Stones
___Frequent bladder infections
___Enlarged Prostate
___Blood in Urine
___**NONE**

Ear, Nose & Throat:
___Sore Throat
___Difficulty Swallowing
___Nose Bleeds
___Bad taste in mouth
___Ear pain
___Sinus Trouble
___Ringing in ears/Hearing Loss
___**NONE**

Gastrointestinal:
___Ulcer
___Nausea
___Vomiting
___Abdominal pain
___Loss of appetite
___Gallbladder Problems
___Reflux/Heartburn
___**NONE**

Neurological/Psychological:
___Headaches
___Memory Loss
___Seizures
___ADD/ADHD
___Tremors
___Depression/Anxiety
___Numbness/Tingling
___Bi-Polar
___ Schizophrenia
___ **NONE**

Patient Signature:____ **Date:**_________________

Physicians Signature:______________________________________ **Date:**_________________

Carl B. Weiss M.D., P.C.

8220 Meadowbridge Rd Suite 303
Mechanicsville VA 23116

Patient Information

Today's Date:__________________ Primary Care Physician: ______________________________

Patient's First Name: Middle: Last: Marital Status (circle one):

______________ ____________ __________________ ___ Single/Mar/Sep/Widow/Divorced

Date of Birth:____________ Social Security #: ____________ Age: _______ Sex: (circle one) Male / Female

Street Address: ____________________City:______________State:_____ Zip Code:____________

Home Phone # _____________ Work Phone # _______________ Cell Phone # ________________

Occupation: ____________________Employer:____________________Phone#____________

How did you hear about our office? ____

Which Pharmacy do you use?______________________ Address:__________________________

Phone #:__________________________________

EMAIL ADDRESS:____

If someone other than yourself is the subscriber for your health insurance please complete the following information:

Subscribers Name: ______________________ Date of Birth __________Relationship:_____________

Race: (circle one) Ethnicity: (circle one)

American Indian or Alaskan Native Asian White Hispanic or Latino

Black/African American Native Hawaiian or Other Pacific Islander Not Hispanic or Latino

What is your primary language? ____

EMERGENCY CONTACT

Name of Contact: __________________Relationship to patient: _____________Phone # ____________

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize this office and the insurance company to release any information required to process my claims.

Patient/Guardian Signature:______________________________________Date: ________________

Carl B. Weiss M.D., P.C.

Treatment Authorization

You consent and understand the following:

- That the attending physician, clinical staff, and technical employees may administer any treatment or perform any procedures deemed advisable for your care or treatment.
- That you have the opportunity to discuss proposed course of treatment with the physician.
- That you have the right to consent or refuse any proposed treatment;
- That in the event of an exposure of a health care provider to your blood or body fluids in a manner which may transmit HIV, Hepatitis B, or Hepatitis C, you hereby consent to the testing of your blood for infections, and to release the results of the blood test to the health care provider that has been exposed.

Privacy and Disclosure

Our Notice of Privacy Practices (NPP) provides information about how we may use and disclose your personal health information (PHI). The terms of our NPP may change in accordance with Federal Regulations. You have the right to review the NPP at any time.

- You have the right to request that we restrict how PHI is disclosed or used. We are not required to agree with this restriction, but if we do, we are bound to said agreement;
- By signing this document you are hereby consenting to our use and release of PHI for treatment, payment, and healthcare operations. You have the right to revoke this consent, in writing, except in the case where disclosure was already made with your consent.
- You have the right to ask any employee of the practice questions pertaining to any information contained in the Notice if Privacy Practices;

Payment Arrangements

- By signing this document you hereby authorize all payments to Carl B. Weiss, M.D., of any insurance benefits, otherwise payable to you for services provided under any insurance policy, (hospitalizations, major medical, worker's compensation, or any other insurance or benefit plan).
- By signing this document, you authorize the release to insurance companies or other third party payers of their agents any medical information which may be necessary to determine coverage or which may be used for utilization and quality review, utilization management, or continued care oversight.
- You are required, and you agree, to pay at the time of service any required co-pays, co-insurance and or deductibles, as well as any charges not covered by health insurance.
- **Unpaid balances will be billed to your permanent address. You are responsible for paying the bill in full unless other arrangements have been approved and put in place. There is a $50 returned check fee. Delinquent accounts will be turned over to our collection attorney at which time you will be responsible for legal fees of 33.33% , in addition to the amount owed.**
- By signing this document, you authorize any photocopies of this document to be as valid as the original.

I have read, understand, and agree to the Treatment, Privacy, and Payment Policies described above.

____

Patient's Signature | Printed Name | Date

Patient Rights and Responsibilities

You have the following rights under state and federal law:

Medical Records. You have the right to obtain and inspect your personal medical records. We may charge you a reasonable fee for copying and mailing your medical records. You may consent in writing to release your records to someone else for any purpose you choose. This could include your attorney, employer, or family. You may revoke this consent at any time. You may ask us not to disclose or use any part of your medical record. This request must be in writing. We are not required to agree to your request if we believe it is in your best interest to permit use and disclosure your information. If you believe something in your medical record is incorrect, you may request an amendment in writing. In certain cases your request may be denied. If we deny your request, you have the right to file a statement, which will be added to your record, along with our response.

Contacting you. You may request that we send information to an alternate address or by alternate means. We will honor such request as long as it is reasonable and we are assured it is correct. We have the right to verify that the payment information provided is correct.

Accounting for disclosure. You may request a listing of any disclosures made regarding your health information, except for information we used for treatment, payment, or information that you gave us specific consent to disclose, including information shared with family members. There may be a cost involved in preparing this list.

Questions and complaints. If you have any questions or wish to have a copy of this policy, or have any complaints you may contact us in writing for further information. You may also complain to the security of health and human services if you believe this practice has violated your privacy rights. We will not retaliate against you for complaining.

Changes in policy. This practice reserves the right to change its privacy policy based on the needs of the practice and changes in state and federal law.

IMPORTANT: Please read all sections before signing. I acknowledge that I have received and read this privacy notice.

____

Patient Signature **Date**

Please list anyone that you would like to have access to your personal health information. If no one please write NONE.

Name:______________________________ Relationship____________________

Name:______________________________ Relationship____________________

Name:______________________________ Relationship____________________

Name:______________________________ Relationship____________________

____

Patient Signature **Date**