WEISS MEDICAL
Allergy, Asthma & Immunology
Pediatrics & Adults

Jeffrey Weiss, MD, Katie Bogusz, MD & Sheenal Patel, MD
44 Route 23 North, Suite 6
Riverdale, NJ 07457
(973) 248-9199

Patient Responsibility Form

We would like to take this opportunity to welcome you to our practice. Please take this opportunity to read and sign this form to acknowledge your understanding of our patient financial policies.

Insurance: We are participating with most plans. We will file all of these insurance claims on your behalf. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. Not all insurance plans cover all services. In the event your insurance plan determines a procedure to be a noncovered benefit, you will be responsible for charges incurred. Payment is due upon receipt of a statement from our office. Late fees will be incurred for balances that are beyond 30 days due.

Co-payments, deductibles and co-insurance: You are required to pay any co-pay, deductible, or co-insurance amount in accordance with your insurance plan. Please be prepared to pay your co-pay at the time of service. If you are unable to pay your co-pay, we will be happy to reschedule your appointment. We accept cash, check, and credit cards.

Minor children: Any charges incurred on a minor child's account will be billed to the parent or guardian of the child. As such, we will need demographic information on the parent/guardian at the time of the child's visit. In the case of divorced parents, the parent bringing the child to his/her appointment will be responsible for any co-pays or balances even if that parent is not the primary subscriber to the child's insurance policy. It is our office policy not to treat minor children unless they are accompanied by a parent or guardian.

Returned checks: will incur a $25 service charge.

Referrals: Your insurance may require a referral to be issued prior to the appointment. You must call your insurance to confirm whether or not you need a referral. Obtaining the referral is your responsibility. If you do not have a referral at the time of the visit, you will have the option to reschedule the appointment, or keep the appointment and be responsible for the payment. It is your responsibility to make a note of your referral's expiration date and number of visits.

Notice of Privacy Practices: I have been offered a copy of the HIPAA Privacy Practice for Jeffrey Weiss, MD, PA Allergy, Asthma, & Immunology. We will not disclose any health information to another person, but may need to advise other family members of any fiscal responsibility due from a mutual guarantor.

Responsibility for payment: I have read and understand the above policies. I agree to accept full financial responsibility. I authorize Jeffrey Weiss, MD, PA to release medical information necessary for claims payments.

_____ _____

Signature of Patient (or Guarantor, if applicable) Date

Please print name of patient: _____

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Patient Registration Form

Patient Information

Patient's First Name (full legal name)		Middle Name		Last Name	
Date of Birth	Gender ☐ M ☐ F	Social Security Number		Marital Status	
Patient's Address		City	State	Zip Code	
Home Phone		Cell Phone		Work Phone	
Do we have our permission to leave messages regarding protected health information? ☐ Yes ☐ No		If yes, with which may we do so? ☐ Home ☐ Cell ☐ Work			
If over 18, Do we have permission to discuss any medical/lab information with anyone else? (Spouse/Parent/Guardian) ☐ Yes ☐ No		If yes, with who may we do so?			
Referred by		Primary Care Physician		Primary Care Physician Phone	
Pharmacy		Pharmacy Phone		Pharmacy Address	

Patient Employer/School Information

Employer/School	Occupation	Employer/School Phone	
Employer/School Address	City	State	Zip Code

Emergency Contact Information

Emergency Contact Name	Emergency Contact Phone	Relation to Patient

Billing and Insurance (insurance card not required, must be completed)

Primary Health Insurance

Insurance Company		Plan	
Policy Holder's Name (full legal name)		Relation to Patient	Policy Holder's Phone Number
Policy Holder's Address		City	State / Zip Code
Policy Holder's Social Security #	Policy Holders Birthdate	Policy Holder's Gender ☐ M ☐ F	

Secondary Health Insurance

Insurance Company		Plan	
Policy Holder's Name (full legal name)		Relation to Patient	Policy Holder's Phone Number
Policy Holder's Address		City	State / Zip Code
Policy Holder's Social Security #	Policy Holders Birthdate	Policy Holder's Gender ☐ M ☐ F	

Signature of patient or legal guardian (if patient < 18 years old) **Date**

Name: _____ Date of Birth: _____ Date of Appointment: _____

Reason for Visit

What brings you to the office today?

_____

_____

_____

Date symptoms started: _____

Have you lost any days from work or school?

☐ Yes ☐ No

Past Medical History

Have you ever had any of the following?

☐ Acne
☐ AIDS / HIV
☐ Anaphylaxis
☐ Alcoholism
☐ Allergies
☐ Anemia
☐ Anxiety Disorder
☐ Arthritis
☐ Asthma
☐ Back Problems
☐ Blood Disorder
☐ Blood Transfusion
☐ Bronchitis
☐ Cancer
☐ COPD
☐ Diabetes
☐ Depression
☐ Ear Problems
☐ Eating Disorder
☐ Eczema
☐ Epilepsy
☐ Gallstones
☐ GERD reflux/heartburn
☐ Glaucoma
☐ Gout
☐ Hay Fever
☐ Headaches
☐ Heart Disease
☐ Hepatitis B
☐ Hepatitis C
☐ High Blood Pressure
☐ High Cholesterol
☐ Hives
☐ Joint Disorder
☐ Kidney Disorder
☐ Kidney Stones
☐ Liver Disorder
☐ Lung Disease
☐ Nasal Polyps
☐ Osteoporosis
☐ Pneumonia
☐ Rheumatic Fever
☐ Sinusitis
☐ Skin Disorder
☐ Sleep Apnea
☐ Stroke
☐ Substance Abuse
☐ Thyroid Problem
☐ Tonsillitis
☐ Tuberculosis
☐ Sexually Transmitted Infection
☐ Other: _____

Hospitalizations & Surgeries

Reason	Date

Medications

What medications are you currently taking?

Name	Dosage	Frequency

Allergies & Asthma History

Are your symptoms worse in certain seasons of the year?

☐ Spring ☐ Summer ☐ Winter ☐ Fall

Are your symptoms worse:

☐ At home ☐ At work ☐ On vacation ☐ Other: _____

Have you ever had an allergy skin test?

☐ Yes ☐ No When? _____

Have you ever had an allergy blood test?

☐ Yes ☐ No When? _____

Have you ever had an allergy shots?

☐ Yes ☐ No When? _____

Have you ever had hives/rashes/any kind of generalized reaction to an allergy shot?

☐ Yes ☐ No When? _____

Have you ever had wheezing or asthma as a reaction to an allergy shot?

☐ Yes ☐ No When? _____

Have you gone to the emergency room for asthma treatment?

☐ Yes ☐ No When? _____

Are you allergic to any of the following?

Medical:

☐ ACE Inhibitors
☐ Adhesive Tape
☐ Anesthetics
☐ Antibiotics
☐ Aspirin
☐ Barbiturates (sleeping pills)
☐ Codeine
☐ Iodine (including contrast dye)
☐ Latex
☐ NSAIDs (Ibuprofen, Advil)
☐ Penicillin
☐ Seizure Medicines
☐ Sulfa

Food:

☐ Dairy ☐ Nuts ☐ Soy
☐ Eggs ☐ Shellfish ☐ Wheat

Environment:

☐ Bee Stings
☐ Cats
☐ Cleaning Agents
☐ Dogs
☐ Dust
☐ Grass Pollen
☐ Mold
☐ Other insect stings
☐ Perfumes
☐ Strong Odors
☐ Tree Pollen
☐ Weed Pollen

Details/Reactions:

_____

_____

_____

Name: _____ Date of Birth: _____ Date of Appointment: _____

Current Height _____

Current Weight _____

Health Maintenance:

Have you had a colonoscopy? ☐ Yes ☐ No
If yes, when was your last colonoscopy?

_____

If no, why not? _____

_____

Have you had a mammogram? ☐ Yes ☐ No ☐ N/A
If yes, when was your last mammogram?

_____

If no, why not? _____

_____

Immunizations:

Did you receive a flu shot this year? ☐ Yes ☐ No
If yes, when? _____

If yes, where? _____

If no, why did you not receive the flu shot? _____

_____

Have you received a pneumonia vaccination? (Answer if >65 years of age) ☐ Yes ☐ No ☐ Not applicable
If yes, when? _____

If yes, where? _____

If no, why not? _____

_____

Social History:

Are you a current smoker? ☐ Yes ☐ No

If yes, how much do you smoke? _____

_____

If yes, how long have you been smoking?

_____

If no, are you a former smoker? ☐ Yes ☐ No

If yes, how much did you smoke and for how long?

_____

When did you quit? _____

Are there smokers in the home? ☐ Yes ☐ No