MADELEINE C. WEISER MD., PC

Teuta Henci MD Nancy Hillis MD Alisa Hoffman MD

PATIENT INFORMATION

Patient Name	Date of Birth	Sex	Date
Address (Street number and name)	Address Line 2 (Apt/Unit/Floor)		
City, State Zip	Social Security #		
Home Phone Number	Parent Phone Number (Specify parent)	Parent Phone Number (Specify parent)	
Email address(es) (Specify parent or patient)			

Please indicate (by circling above) your preferred method of contact, either home phone, parent phone or email

PATIENT DEMOGRAPHIC INFORMATION

Patient Race (Circle all that apply)

Caucasian (White) Black Hispanic Asian (Includes Indian) Native American Asian Pacific American Pacific Islander Asian American

Preferred Pharmacy (Name & Phone Number)	Known Allergies (Specify Reaction) If no known allergies, please write NONE

Preferred Primary Physician (circle one)

Madeleine Weiser MD Teuta Henci MD Alisa Hoffman MD Nancy Hillis MD No Preference

PERSON RESPONSIBLE FOR CHARGES

Name of Responsible Party (Guarantor)	Date of Birth	
Address - Street	Guarantor Social Security #	
City, State Zip	Home Phone Number	Work Phone Number

INSURANCE INFORMATION

Name of Primary Insurance		Name of Secondary Insurance	
Policy Holder/Subscriber	Date of Birth	Policy Holder/Subscriber	Date of Birth
Insured ID/Policy Number	Group Number	Insured ID/Policy Number	Group Number
Insurance Effective Dates	Copay Amount	Insurance Effective Dates	Copay Amount

EMERGENCY CONTACT INFORMATION

Contact Name		Relationship	
Home Phone Number	Work Phone Number Ext	Cell Phone Number	

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize payments of medical benefits to the provider for services rendered, or to be rendered in the future, without obtaining my signature on each claim submitted and the signature will bind me as though I personally signed the claim. I also authorize the release of any medical information necessary. I UNDERSTAND I AM RESPONSIBLE FOR ALL CHARGES. If this account should be referred to a collection agency, I will be responsible for any collection and/or legal fees. I have read and understand the office policy and procedures.

Responsible Party Signature Date

MADELEINE C. WEISER MD., PC

Teuta Henci MD Nancy Hillis MD Alisa Hoffman MD

Patient Information and Medical History

PLEASE PRINT CLEARLY

Patient Name: _____ M ☐ F ☐ DOB: ____/____/_____

BIRTH HISTORY

Hospital: _____ Vaginal ☐ C-Section ☐ Adopted ☐

Birth Weight: _____ Weeks Gestation at Birth: _____

Complications: _____

PATIENT'S MEDICAL HISTORY

Illnesses/Conditions: _____

Current Medications: _____

Allergies: • _____ Reaction: _____

• _____ Reaction: _____

• _____ Reaction: _____

Hospitalization/Surgery:

Date: _____ Details: _____

Date: _____ Details: _____

Date: _____ Details: _____

HOME LIFE

Primary language spoken at home: _____

Parents/Guardians ☐ Married ☐ Single ☐ Divorced - Lives with _____

1. Name: _____ M ☐ F ☐ DOB: ___/___/_____ Relation to Patient: _____
2. Name: _____ M ☐ F ☐ DOB: ___/___/_____ Relation to Patient: _____

Address of parent/guardian (if different than patient): _____

Siblings City/State/Zip: _____

Name: _____ M ☐ F ☐ DOB: ___/___/_____

Name: _____ M ☐ F ☐ DOB: ___/___/_____

Name: _____ M ☐ F ☐ DOB: ___/___/_____

Additional members of household: _____

FAMILY HISTORY

Does anyone in your family have any of the following?:

	No	Yes	Relationship To Patient		No	Yes	Relationship To Patient
Alcoholism	___	___	_____	High Blood Pres	___	___	_____
Allergies	___	___	_____	Kidney Disease	___	___	_____
Asthma	___	___	_____	Lead poisoning	___	___	_____
Cancer	___	___	_____	Mental Illness	___	___	_____
Diabetes	___	___	_____	Mental Retardation	___	___	_____
Drug Abuse	___	___	_____	Rheumatic Fever	___	___	_____
Early Infant Death	___	___	_____	Seizure Disorder	___	___	_____
G6PD	___	___	_____	Sickle Cell Disease	___	___	_____
Heart Disease	___	___	_____	Tuberculosis	___	___	_____

Please list other medical histories/conditions/illnesses of family members:

_____