



Patient Information Sheet

Stephen P. Weiss, M.D., P.A. 7-09

Patient Last Name _____ First Name _____ MI _____

Patient Address _____

City _____ State _____ Zip _____

Patient Birth Date _____ Age: _____ Sex: M F

Home Telephone _____ Work Telephone _____

Cell Phone _____ SSN# _____

E-Mail Address: _____

Emergency Contact: _____

Marital Status (circle one): Single Married Divorced Widowed Legally separated

How did you hear about us? _____

Insurance Information

Name of Insured _____ Relationship (circle one) Self Spouse Child

Insurance Company _____ Phone _____

Policy or ID Number _____ Group Number _____

Is this a Worker's Compensation Claim? Yes No

Stephen P. Weiss, M.D., P.A

Welcome to the office of Dr. Stephen Weiss. Our goal is to offer you the absolute highest quality health and medical services available, blending the best of Western and Alternative Medicine. Dr. Weiss has extensive post graduate training in many areas which he draws upon in his Holistic Practice, including homeopathy, herbs, nutrition, Ayurveda, emotional and spiritual counseling, and lifestyle modification. We use traditional therapies and medications when appropriate, and perform wellness exams and annual gynecological check-ups. The best medicine enhances the body's natural ability to remove obstacles to the healing process. For this reason, we use homeopathic remedies and herbal and nutritional substances as our first line of treatment when appropriate. We encourage our patients to make health a priority. We hope your relationship with us will include a willingness to make changes in your life patterns and allow us to educate and advise you toward a more total integration of physical, emotional and spiritual health.

Please read this office policy to familiarize yourself with the general policies of our office. If you have any questions, please ask the front desk staff for clarification. Once you understand our policies, sign and return this form to the front desk. Again, we hope your experience with us is of great benefit to your total health and well-being.

Please initial that you have read and understand the policies below:

FINANCIAL POLICY

_____ All services rendered will be paid in full unless prior arrangements have been made. Please see the front desk personnel about an appointment to discuss arrangements. We accept cash, personal check or MasterCard, VISA, and Discover. The return check fee is \$25. Please feel free to ask questions, we will discuss our professional fees with you at any time.

INSURANCE

_____ Your medical insurance is a contract between you and your insurance company to which we are not a party. At the time of medical service we will provide you with a "claim" that you can file with your insurance for reimbursement. We do not accept medical insurance assignment.

INSURANCE & WORKERS COMPENSATION

_____ **We do not accept Workers' Compensation and are not contracted with any insurance company.** Check with your insurance carrier to see if your visit to our office will be covered and to what extent. Many insurance plans do cover a portion of our fees.

APPOINTMENTS

_____ Our office is often quite busy. Due to the complexities of patient care and an individual patient's condition, we occasionally fall behind. Be assured that you will receive the same individual attention when you are seen. We respect your time and ask you to respect ours as well by being on time for appointments. We also try to keep daily appointment slots available for established patients who have urgent medical problems.

CANCELLATION POLICY

_____ **We have a 24 hour cancellation policy.** If you cancel or miss an appointment without 24-hour notice, we will have to charge you for the visit. **For new patient visits we request 48 hours notice.** Our services are in great demand, and we need to offer your appointment slot to another patient if you cannot be here.

TELEPHONE CONSULTATIONS

_____ We are now able to answer only brief questions over the telephone (i.e., 2-3 minutes) relating to a recent office visit or other simple matters. Longer phone consultations and those pertaining to a new medical problem or one not recently discussed, will be billed at rates equivalent to those charged for office visits. We regret this, but the volume of calls we receive each day has necessitated a change in office policy. We try to answer calls in a timely fashion by the end of each day. If you have an extremely urgent situation/question, please indicate this to the office manager when you call.

EMERGENCIES/ AFTER HOURS & WEEKEND COVERAGE

_____ Our practice is an out-patient practice. We do not see or follow patients in the hospital. Medical problems requiring admission to a hospital will be referred to hospital-based physicians or the physician on call at the hospital. Dr. Weiss works as a specialist/consultant in Integrative Medicine, not as a primary care physician (PCP). If a problem arises after normal business hours or on Fridays, Saturdays, or Sundays and you feel you need medical attention, please go to Urgent Care. Patients taking homeopathic remedies will be given specific instructions about after hours homeopathic coverage at the time of their office visit.

CLASSICAL HOMEOPATHY

_____ Dr. Weiss treats patients with a wide array of natural substances as well as with western medications when appropriate. Some of you will be treated with homeopathic remedies, either because you have requested this form of treatment or because Dr. Weiss believes it is most likely to help with your specific problem(s). Patients seen for Classical Homeopathy will have either a 2 hour initial visit or two 1 hour visits (the latter is usually better reimbursed by insurance) and then are expected to be seen in 4 weeks for a 30 minute follow-up visit. This visit is crucial to assess your progress and adjust your remedy if needed. If a problem should arise in between visits, please contact the office for advice. Also, please refrain from using any other homeopathic medicine or other alternative treatments, unless you have cleared it with us. You will be required to refrain from consuming all products containing regular or decaffeinated coffee, mint, (to include mint toothpaste) and to avoid aromatic, strong-smelling substances such as camphor (found in Ben Gay, Chapstick), perfume, tea tree oil, etc... Any dental work required should be completed before you take your homeopathic treatment. If it has been over a year since your last dental check-up, we suggest you see your dentist prior to initiating homeopathic care.

PERFUME OR COLOGNE

_____ We ask that on the day of your appointment that you do not wear perfume, cologne, or scented body lotion. Many of our patients are chemically sensitive or are allergic, and become ill when exposed.

Thank you for reading and understanding our office policy. Please let us know if you have any questions. Our intention is to serve the community as best we can with the safest and most effective treatments available. Your personal referrals are greatly appreciated.

Name _____ Signature _____ Date _____

Stephen P. Weiss, M.D.

4137 Montgomery NE, Albuquerque, NM 87109.

Phone: (505) 872-2611 Fax: (505) 830-4648

Name: _____ Date of Birth: _____

Have you, or has anyone in your immediate family, had problems with the following:

Indicate with an "X" if this problem has affected you.

Indicate with an "S" if this problem has affected anyone in your immediate family.

- | | |
|-------------------------|------------------------------------|
| _____ Allergies | _____ Migraine headaches |
| _____ Anemia | _____ Rheumatic fever |
| _____ Alcoholism | _____ Stroke |
| _____ Bleeding problems | _____ Suicide |
| _____ Birth defects | _____ Thyroid disease |
| _____ Cancer | _____ Tuberculosis |
| _____ Emphysema | _____ Ulcers |
| _____ Epilepsy | _____ Sexually transmitted disease |
| _____ Heart trouble | _____ Osteoporosis |
| _____ Glaucoma | _____ Mental illness |
| _____ Diabetes | _____ Hypertension |
| _____ Fibromyalgia | _____ Chronic fatigue |
| _____ Lupus | _____ Rheumatoid arthritis |
| _____ Hepatitis | _____ Asthma |

Any other serious illnesses not listed?

Do you have any allergies? (medications, food, inhalants) Please list.

Please, list all prescription medications, over the counter remedies, vitamins, and/or herbs you are taking, including the dose. Use another sheet of paper if necessary.

Health Habits: Do you smoke or chew tobacco? _____ # of packs per day _____
 Have you ever smoked in the past? _____ Date started _____ stopped _____
 Are you taking a multi-vitamin? _____
 If you take a multi-vitamin, do you take the recommended dose on the bottle? _____
 On average, how many servings of fruit & vegetables do you have a day? _____

ONE SERVING EQUALS

One medium fruit or 1/2 cup of small or cut-up fruit, OR
 3/4 cup (180 milliliters) of 100 percent juice, OR
 1/4 cup dried fruit, OR
 1/2 cup raw non-leafy or cooked vegetables, OR
 1 cup raw leafy vegetables (such as spinach)

Do you have any dietary restrictions/ preferences? _____
 How many cups of caffeinated coffee/tea do you drink per day? _____
 How many sodas do you drink per day? _____ Do you eat a low fat diet? _____
 What do you do to relieve stress? _____
 Do you ever have problems sleeping at night? _____
 What type of alcohol do you drink and how often? _____
 What is your occupation? _____
 Do you live with anyone? _____ If yes, who? _____
 Do you have any children? _____ If yes, how old? _____
 Are you sexually active? _____ If yes, is sex satisfactory? Y N
 Sexual orientation: Heterosexual _____ Homosexual _____ Bisexual _____
 What type and how often do you exercise? _____
 Are you trying to lose weight? _____ If yes, how? _____
 Do you have an eating problem? _____
 On scale of 1-10 (10 being the highest)- how happy are you with your lifestyle and health? _____ What would you most like to change? _____

 Does spirituality or religion play an important part in your life? If yes, describe _____

Review of Systems: do you have any problems with the following?

_____ Constipation	_____ Diarrhea	_____ Gas
_____ Headaches	_____ Indigestion	_____ Heartburn
_____ Anxiety	_____ Depression	_____ Sugar Cravings
_____ Eczema	_____ Psoriasis	_____ Skin rashes
_____ Fatigue	_____ Joint pain	_____ Yeast infections
_____ Acne	_____ Bleeding gums	_____ Feeling "cold"
_____ Chest pain	_____ Difficulty breathing	_____ Urinating
_____ Leg swelling	_____ Hot flashes	_____ Menstrual cramps
_____ Back Pain	_____ Muscular pain	_____ Memory loss

For Women:

Date of last menstrual period? _____ Are you pregnant? _____
Are your periods regular? _____ No. of days your period lasts _____
Spotting between periods? _____
PMS? _____
Date of last pap smear? _____ Have you ever had an abnormal pap smear? _____
What type of contraception do you use? _____
Date of last mammogram? _____ Was it normal? _____
How many times have you been pregnant? _____ No. of live births _____
If you are in menopause, do you wish of take hormone replacement therapy? _____
Are you interested in alternatives to hormone replacement therapy? _____

For Men:

Date of last Prostate Cancer Screen with PSA: _____

Thank you for taking the time to fill out this information. This information is confidential, and will not be shared unless a written consent is on file.

Stephen P. Weiss, M.D., P.A.

Osteoporosis Risk Evaluation

Osteoporosis is a disease that usually affects seniors and the elderly, where the bones thin and weaken from calcium depletion. Osteoporosis affects an estimated 10 million people in the USA. Fifty per cent of women over 50 in the USA will have an osteoporosis related fracture during their lifetime (National Osteoporosis Foundation, 2004). Twenty-five per cent of men over 50 in the USA will have an osteoporosis related fracture during their lifetime (National Osteoporosis Foundation, 2004).

NAME: _____

DOB: _____ Height: _____ Weight: _____

Menopausal years (if applicable): _____ Age: _____ Sex: M / F

Please check all that apply

Anorexia (previous or current)	An estrogen-deficient woman	Vegetarianism	
Hyperthyroidism, Cushing's Disease, etc.	Low body weight (below 127 lbs)	Previous/current cigarette smoking	
Prostate Cancer	Personal history of a previous fracture	Family history of osteoporosis	
Caucasian or Asian	Height loss	Long-term thyroid replacement	
Current steroid use (or significant steroid use in the past, including inhaled)	Lactose intolerance	Early menopause	
Inadequate calcium intake	On HRT for prolonged periods	Breast cancer	
Hypercalciuria	Rheumatoid arthritis	Vitamin D deficiency	
Malabsorption or celiac disease	Other (Specify)		

We now offer accurate bone density testing of the wrist ("peripheral DEXA) in our office, as well as effective natural & pharmaceutical options for reversing bone loss. Anyone with even a single risk factor would benefit from bone density testing. The cost of bone density test is \$45.00.

- I would like to have my bone density tested in the office
(Your DEXA Scan can be done on the day of your new patient appointment and usually takes no more than 10 minutes).
- I do not want to have my bone density tested in the office
- I would like to discuss this further with Dr. Weiss