



Dr. Craig Weingrow MD

Dr. Jacqueline Leventhal DO

Full Name:		Sex M / F
Date of Birth:	Marital Status: S M D W	Height__ft__in Weight___lbs
Home Address: Apt_____		SSN:
City:	State: Zip:	Please initial below. I understand that I am responsible for all fees associated with text messaging
Home Phone:	Cell Phone	I allow Text messages ____
Email Address		I allow messages via email ____
How Did you hear about us? Website Insurance Company Friend/Family Newsletter Event_____		Media Social
Patient Employer		
Employer:	Hrs/Week_____	Phone:
Address	Ste	N/A Lt Labor Mod Labor
City:	State: Zip:	Heavy Labor Office/Clerical
Guarantor		
Guarantor Name:		
Relationship to Guarantor:	Spouse Parent Sibling Child Aunt/Uncle	Legal Guardian Other
Address:		Phone:
City:	State: Zip:	Cell:
Spouse Name and Emergency Contact		
Spouse Name:		Cell Phone:
Spouse Place of Work:		Home Phone:
Emergency Contact:	Relation	Phone
Insurance Information		Do you have Medicare: Yes / No
Primary Insurance:		Phone:
ID #:		Group #:
Insured Name:		Relationship: Spouse Parent
Insured DOB:		Insured SSN#:
Secondary Insurance:		Phone:
ID #:		Group #:
Insured Name:		Relationship: Spouse Parent
Insured DOB:		Insured SSN#:



Dr. Craig Weingrow MD      Dr. Jacqueline Leventhal DO

# HEALTH HISTORY

Name: \_\_\_\_\_

Birth date: \_\_\_/\_\_\_/\_\_\_      Age: \_\_\_\_\_

Marital Status: \_\_\_\_\_

Level Of Education: \_\_\_\_\_

Current Occupation: \_\_\_\_\_

Is Your Occupation enjoyable?      Y / N

Is it stressful?      Y / N      Is it fulfilling      Y / N

Hazardous Material Exposure?      Y / N

If retired, what was your main occupation? \_\_\_\_\_

YOUR GOALS:

\_\_\_\_\_  
 \_\_\_\_\_

PRESCRIPTION & OVER THE COUNTER MEDICATIONS

PLEASE LIST ACTIVE MEDICAL PROBLEMS:

YOU ARE CURRENTLY TAKING:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

ALLERGIES – DRUGS:

FOODS:

NUTRIENTS/SUPPLIMENTS you are taking:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

CONDITIONS: Check any other conditions you have ever had in the past & indicate what year

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> AIDS/HIV+        | <input type="checkbox"/> Allergies/Asthma  | <input type="checkbox"/> Anemia              | <input type="checkbox"/> Alcohol/Drug Problem   |
| <input type="checkbox"/> Anorexia/Bulimia | <input type="checkbox"/> Arthritis         | <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Anxiety/Panic Disorder |
| <input type="checkbox"/> Back Pain        | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Candida/Yeast       | <input type="checkbox"/> Cancer-Specify _____   |
| <input type="checkbox"/> Chronic Fatigue  | <input type="checkbox"/> Crohn's Disease   | <input type="checkbox"/> Colitis             | <input type="checkbox"/> Diabetes – Type I II   |
| <input type="checkbox"/> Depression       | <input type="checkbox"/> Emphysema         | <input type="checkbox"/> Epilepsy/Seizures   | <input type="checkbox"/> Fibromyalgia           |
| <input type="checkbox"/> Glaucoma         | <input type="checkbox"/> Goiter            | <input type="checkbox"/> Gout                | <input type="checkbox"/> Hiatal Hernia/Reflux   |
| <input type="checkbox"/> Heart Disease    | <input type="checkbox"/> High Cholesterol  | <input type="checkbox"/> Irritable Bowel     | <input type="checkbox"/> Hypertension/ High BP  |
| <input type="checkbox"/> Jaundice         | <input type="checkbox"/> Kidney Disorder   | <input type="checkbox"/> Kidney Stones       | <input type="checkbox"/> Liver Disease          |
| <input type="checkbox"/> Hepatitis        | <input type="checkbox"/> Migraines         | <input type="checkbox"/> Multiple Sclerosis  | <input type="checkbox"/> Osteoporosis           |
| <input type="checkbox"/> Pancreatitis     | <input type="checkbox"/> Polio             | <input type="checkbox"/> Prostate Problem    | <input type="checkbox"/> Rheumatic Fever        |
| <input type="checkbox"/> Pneumonia        | <input type="checkbox"/> Sinusitis         | <input type="checkbox"/> Stroke/TIA          | <input type="checkbox"/> Suicide Attempt        |
| <input type="checkbox"/> Root Canal       | <input type="checkbox"/> TMJ               | <input type="checkbox"/> Tooth Abscess       | <input type="checkbox"/> Tuberculosis           |
| <input type="checkbox"/> Thyroid Problem  | <input type="checkbox"/> Urinary Infection | <input type="checkbox"/> OTHER: _____        |   |
| <input type="checkbox"/> Ulcers           | _____                                      |  |   |

# WEINGROW

WELLNESS & MEDICAL CENTER

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**CURRENT OR RECENT SYMPTOMS:** Check any symptoms that you have noticed recently.

- |  |   |  |  |   |
|--|---|--|--|---|
| <input type="checkbox"/> Chest pain                    | <input type="checkbox"/> Blood in sputum        | <input type="checkbox"/> Fainting/Collapse | <input type="checkbox"/> Leg pain w/walking    | <input type="checkbox"/> Kidney pain            |
| <input type="checkbox"/> Nose bleeds                   | <input type="checkbox"/> Shortness of breath    | <input type="checkbox"/> Swollen Ankles    | <input type="checkbox"/> Snoring excessively   | <input type="checkbox"/> Blood in urine         |
| <input type="checkbox"/> Abdominal pain                | <input type="checkbox"/> Acid reflux            | <input type="checkbox"/> Black terry stool | <input type="checkbox"/> Bright blood in stool | <input type="checkbox"/> Frequency of urination |
| <input type="checkbox"/> Difficulty swallowing         | <input type="checkbox"/> Loss of appetite       | <input type="checkbox"/> Persistent nausea | <input type="checkbox"/> Mood swings           | <input type="checkbox"/> Urgency of urination   |
| <input type="checkbox"/> Change in headaches           | <input type="checkbox"/> Double vision          | <input type="checkbox"/> Dizzy/Spinning    | <input type="checkbox"/> Eye pain              | <input type="checkbox"/> Bone pain              |
| <input type="checkbox"/> Unusual bruising              | <input type="checkbox"/> Prolonged bleeding     | <input type="checkbox"/> Bloating          | <input type="checkbox"/> Excessive thirst      | <input type="checkbox"/> Rapid heart beat       |
| <input type="checkbox"/> Recent Changes in bowel habit | <input type="checkbox"/> Weight loss-unexpected | <input type="checkbox"/> Other symptoms:   | _____  |   |

**HOSPITALIZATIONS:** Please include surgeries, illness, severe accidents, births, miscarriages:

Year:	Procedure:	Reason:	Outcome:

**FAMILY HISTORY:** Please complete health information about your family:

Relation	Age	State of Health	Age at Death	Cause of Death	<input checked="" type="checkbox"/>	Check if your blood relatives had any of the following:	Relation to you:
Father					<input type="checkbox"/>	Arthritis/Gout	
Mother					<input type="checkbox"/>	Asthma/Hay Fever	
Brothers					<input type="checkbox"/>	Cancer:Where:	
					<input type="checkbox"/>	Drugs/Alcohol	
					<input type="checkbox"/>	Diabetes	
					<input type="checkbox"/>	Heart Disease	
Sisters					<input type="checkbox"/>	High Blood Pressur	
					<input type="checkbox"/>	Osteoporosis	
					<input type="checkbox"/>	Stroke	
					<input type="checkbox"/>	Tuberculosis	

**RECENT TESTS:** If you have had any of these tests please complete:

TEST:	Date:	Reason:	Result:
Chest X-Ray			
EKG			
EGD(Stomach)			
Colonoscopy			
Ultrasound			
CAT Scan			
MRI Scan			
Bone Density			

**HEALTH HABITS:** Which substances do you consume:

Substance:	How Much?
Caffeine	Cups/Cans
Cigarettes	Packs/Day
Are you interested in quitting? Y / N	
Alcohol	Type Amount
Drugs Y / N	What Amount
Chew Tobacco Y / N	Amount Years
Nutrasweet	Servings per day:
Sacchain	Servings per day:

7200 Smoke Ranch Rd#120 Las Vegas, NV 89128

Phone (702)570-6611

Fax (702)570-5636

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### Skin/Integumentary:

- Dry skin
- Thin lips
- Graying hair
- Skin blemishes
- Thin brittle nails
- Tendency to bruising
- Thinned skin-hands, face, arms
- Thinning hair-scalp, armpits, legs
- Wrinkling skin-face, neck, hands, arms
- Sagging skin-under eyes, arms, face, breasts

### Neuro-cognitive:

- Loss of esteem
- Feeling hopeless
- Feeling defeated
- Loss of confidence
- Vision deteriorating
- Hearing deteriorating
- Memory deteriorating
- Sense of powerlessness
- Decreased sense of wellbeing

### Gastrointestinal:

- Feel full faster
- Slower digestion
- Fullness after meals
- Eat less/Smaller meals
- Indigestion
- Burping/belching after meals
- Decreased sense of taste/smell

### Muscle/Joints:

- Osteoporosis
- Aches and Pains
- Loss of strength
- Body & joints stiff
- Balance deteriorating
- Coordination deteriorating
- Thinning muscles
- buttocks, arms, legs

**Diet:** Are you on any specific diet? (Please specify: \_\_\_\_\_). Successful? Y / N

List which diets have been successful in the past: \_\_\_\_\_

### Stress:

Rate your current stress level: (Please circle) Extreme High Medium Low

How long has it been like this? \_\_\_\_\_

You expect this to last a (Please circle) Short Medium Long period of time.

### Exercise:

 Please circle which you do.

Aerobic      Weights      Walking      Other: \_\_\_\_\_

How long are your workout sessions? \_\_\_\_\_ How many days/week? \_\_\_\_\_

### Sleep:

 Please check the symptoms that you notice.

- Trouble getting to sleep – racing mind
- Sleep not as restful/Wake up not rested
- Wake up through the night feeling like you are choking or having a smothered sensation
- Your partner has noticed very heavy snoring during sleep
- Your partner has noticed that you stop breathing through the night with heavy snoring
- Daytime drowsiness or sleepiness especially with periods of inactivity
- Toss and turn through night/wake frequently through the night

Take a moment to reflect on your response to the following question:

On a scale of 0-5(5 being the strongest response), circle your response:

How important and committed are you to improving your current health? 0      1      2      3      4      5

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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**CONTROLLED SUBSTANCE CONTRACT**

The patient has been prescribed a controlled substance at this time. The patient shows no signs of addiction or abuse and is using the medication appropriately, as prescribed. The patient has not requested early refills. There are no side effects related to this medication at this current time. The patient denies having received and opioid medications from any other physicians, while being treated with opioid medications through my clinic.

The patient was reminded that any controlled release medications should not be crushed, chewed or broken prior to ingestion. The patient understands the risks, benefits and alternatives to taking opioid medications and realizes that these medications are potentially addictive. The patient agrees to receive these medications from my office only. The patient was cautioned against driving while taking the opioid medications. The patient was informed that the product insert should be carefully reviewed personally, prior to starting any new medications.

The patient understands that chronic use of pain medications can result in renal or hepatic dysfunction.

The patient will follow up in our office in 4 (four) weeks for reevaluation. If the patient has any problems or questions they will contact our office.

\_\_\_\_\_  
Signature of Patient/Parent/Legal Guardian

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of Patient

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Patient Date of Birth

\_\_\_\_\_  
Witness                                  Job Title



INJECTION WAIVER

DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

I understand that my physician will not bill my health insurance for the medication used in the injections or immunizations I am to receive. I agree to pay for these services on the date of service.

I understand that I have the option of taking a written prescription to the pharmacy, picking up the medication and returning to the office to have the shot administered. The office will charge for the administration of the injection/immunizations.

I have been advised to wait 20 minutes in the office once the injection/immunization has been administered.

Patient Name: \_\_\_\_\_

Signature: \_\_\_\_\_



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### Financial Policy

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Thank you for choosing us as your healthcare provider. The following is our Financial Policy. If you have any questions or concern about our payment policies, please do not hesitate to ask our billing department (702)570-6611.

1. Your insurance policy is a contract between you, your employer, and the insurance company. Our relationship is with you, not your insurance company. All services are provided to you with the understanding that you are responsible for their cost regardless of your insurance coverage. If you would like to know the cost of a service, please inquire with the staff prior to treatment. Please be aware that not all services are a covered benefit in all insurance policies. You are responsible for knowing, per your insurance plan on what services are or are not covered. **Fees for these services, along with any unpaid deductible and co-payment are due prior to the time of treatment.** You are responsible for these amounts.
2. You are responsible for knowing your insurance benefits. Does your insurance require a referral? What facilities participate in your plan? If we can be of assistance, please let us know. We are sure that we can answer most questions regarding your insurance.
3. We will send you a statement monthly to keep you informed on the status of your account until the account is paid in full or placed in collection.
4. We will bill the insurance information you provided to us **as a courtesy**, but you are still ultimately responsible for payment of any services you receive. We will also follow up on your claim. We will be checking with your carrier once verbally and once in writing. If, however, your insurance does not respond to us within 60 days of claim submission, the amount will become your responsibility and you will have to follow up with your carrier for payment of the claim.
5. If your medical claim has not been paid by your insurance company, and you have contacted them with no results, there is recourse for you. The Nevada Department of Business and Industry has established an insurance division to receive questions, complaints, and comments from the consumers in Nevada concerning healthcare plans. Their address is 555 E. Washington Ave., Las Vegas, NV 89101 and phone number is (702)486-4000.
6. If you are a Medicare beneficiary by Federal Law we are required to collect 20% of the "Medicare Assignment" portion which the Federal Government does not pay. Medicare will only pay 80% of the assigned amount after your deductible has been paid. Again, if you have financial problems or questions, please ask for our Office Manager or Billing Department.
7. Failure to cancel or reschedule an appointment without 24 hour notice will result in a \$25 fee. No Exceptions.

By signing this agreement I acknowledge that I have personally guaranteed the debts and obligations incurred by me, and agree that I am personally obligated to perform all of the terms of, and make payments to Weingrow Wellness required by, the agreement of which this application is a part. I authorize this office to release any necessary information to third parties when requested and if I become delinquent and my account is assigned over to a collection agency associate that they are hereby given the right to report same accurately to all the Credit Bureaus. I agree to pay all collection expenses Weingrow Wellness may incur in the collection of any delinquent balance plus, attorney's fees, court costs, filing fees including charges or commissions that may be assessed by any collection agency retained to pursue this matter. Collection fees will be 40% for regular collections and 50% for legal collections or forwards, which may be as much as twice the original balance owing. Patient further agrees to pay interest rate of 2% per month, 24 % per year from the first date the account becomes delinquent.

I understand all of the above and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Weingrow Wellness will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the convenience of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. Please be aware that we do understand any temporary problems one may have at the time of the visit. We encourage you to make us aware of this prior to the treatment, so we can assist you in any way regarding your balance. **OUR MAIN CONCERN IS OUR PATIENTS WELL BEING.**

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date



WELLNESS & MEDICAL CENTER  
Dr. Craig Weingrow MD Dr. Jacqueline Leventhal DO

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I hereby authorize the following physician/facility to release my protected health information:

Previous Physician/Facility: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Information to be disclosed (Check all that apply):

- Complete Health Records
- Hospital Records
- Progress Notes Only
- Radiology Reports & Laboratory Tests
- Other (Please Specify): \_\_\_\_\_

I UNDERSTAND THAT THESE WILL INCLUDE INFORMATION RELATING TO:

- Human Immunodeficiency Virus (HIV) Infection
- Behavioral Health Services/Psychiatric Care
- Treatment for Alcohol/Drug Abuse

Please release the above noted medical records to: (Circle One)

Dr. Craig Weingrow MD

Dr. Jacqueline Leventhal DO

7200 Smoke Ranch Rd #120

Las Vegas, NV 89128

Phone: (702) 570-6611 Fax: (702) 570-5636

I certify that I have read and upon request will receive a copy of this Authorization.

I agree to this release of health information as described herein.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
(Legal Representative) Print

\_\_\_\_\_  
(Legal Representative) Sign

\_\_\_\_\_  
Date

DOB: \_\_\_\_\_

SS#: \_\_\_\_\_

Contact #: \_\_\_\_\_

Failure to provide us with the above information will prevent this transfer from being processed.

7200 Smoke Ranch Rd#120 Las Vegas, NV 89128 Phone (702)570-6611 Fax (702)570-5636





WELLNESS & MEDICAL CENTER

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PREFERRED PHARMACY:

Pharmacy Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone Number : \_\_\_\_\_

Fax Number: \_\_\_\_\_