

**BRENT A. RUBIS, M.D.**

PATIENT INFORMATION

PATIENT NAME \_\_\_\_\_ AGE \_\_\_\_\_ BIRTHDATE \_\_\_\_\_  
SOCIAL SECURITY NO. \_\_\_\_\_  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
CELL PHONE \_\_\_\_\_ EMAIL ADDRESS \_\_\_\_\_  
MAY WE EMAIL YOU INFORMATIONAL UPDATES/NEWSLETTERS YES \_\_\_\_\_ NO \_\_\_\_\_  
  
SINGLE \_\_\_\_\_ MARRIED \_\_\_\_\_ DIVORCED \_\_\_\_\_ WIDOWED \_\_\_\_\_ OTHER \_\_\_\_\_  
MALE \_\_\_\_\_ FEMALE \_\_\_\_\_  
EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_  
EMERGENCY CONTACT \_\_\_\_\_ PHONE \_\_\_\_\_ RELATION \_\_\_\_\_

RESPONSIBLE PARTY

RESPONSIBLE PARTY \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
SOCIAL SECURITY NUMBER \_\_\_\_\_ BIRTHDATE \_\_\_\_\_  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_

PRIMARY CARE PHYSICIAN \_\_\_\_\_  
REFERRED BY: Physician: \_\_\_\_\_ Yellow Pages: \_\_\_\_\_  
Website: \_\_\_\_\_ Personal: \_\_\_\_\_  
CHIEF COMPLAINT \_\_\_\_\_ INJURY DATE \_\_\_\_\_  
IS THIS WORK RELATED? \_\_\_\_\_ DUE TO MOTOR VEHICLE ACCIDENT? \_\_\_\_\_  
OTHER ACCIDENT? \_\_\_\_\_  
IF HAND INJURY-ARE YOU RIGHT OR LEFT HANDED? \_\_\_\_\_

ASSIGNMENT OF BENEFITS: I HEREBY ASSIGN ALL MEDICAL AND/OR SURGICAL BENEFITS TO INCLUDE MAJOR MEDICAL BENEFITS TO WHICH I AM ENTITLED, INCLUDING MEDICARE, PRIVATE INSURANCE, AND ANY OTHER HEALTH PLAN TO DR. BRENT RUBIS. THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDERED VALID AS AN ORIGINAL. I HEREBY AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION NECESSARY TO SECURE THIS PAYMENT. I AGREE TO PAY ALL CHARGES NOT COVERED BY INSURANCE.

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

**FAMILY HISTORY:** Has any blood relative ever had the following:

Breast Cancer.....	No	Yes	High blood pressure.....	No	Yes	Kidney disease.....	No	Yes
Melanoma.....	No	Yes	Heart disease.....	No	Yes	Depression.....	No	Yes
Stroke.....	No	Yes	Diabetes.....	No	Yes	DVT (clots in legs).....	No	Yes

**PAST MEDICAL HISTORY:** Have you ever had the following:

Heart conditions.....	No	Yes	Cancer.....	No	Yes	Stomach Ulcer.....	No	Yes
Arthritis.....	No	Yes	Glaucoma.....	No	Yes	Kidney problems.....	No	Yes
Rheumatic fever.....	No	Yes	Asthma.....	No	Yes	Thyroid problems.....	No	Yes
Anemia.....	No	Yes	AIDS or HIV+.....	No	Yes	Bleeding tendency.....	No	Yes
Tuberculosis.....	No	Yes	Stroke.....	No	Yes	Diabetes.....	No	Yes
Hepatitis.....	No	Yes	High blood pressure.....	No	Yes	DVT (clots in legs).....	No	Yes
Migraines.....	No	Yes	Blood transfusion.....	No	Yes	Reactions to anesthesia..	No	Yes
Other _____								

**REVIEW OF SYSTEMS:** Do you now or have you had any of these within the past year:

Weight change.....	No	Yes	Swollen feet/ankles.....	No	Yes	Seizures.....	No	Yes
Dry eyes.....	No	Yes	Skin rash.....	No	Yes	Joint or muscle pain....	No	Yes
Chronic cough.....	No	Yes	Chronic diarrhea.....	No	Yes	Swollen lymph nodes...No	Yes	
Chest pain.....	No	Yes	Jaundice.....	No	Yes	Easy bleeding.....	No	Yes
Rapid heart beat.....	No	Yes	Depression.....	No	Yes	Easy bruising.....	No	Yes

Height \_\_\_\_\_  
Weight \_\_\_\_\_

**WOMEN ONLY:**

Date of last mammogram \_\_\_\_\_  
Previous breast biopsy? No Yes  
Number of pregnancies \_\_\_\_\_  
Number of live births \_\_\_\_\_  
Number of C-Sections \_\_\_\_\_

**SMOKING HISTORY:** No Yes  
Number of packs per/day \_\_\_\_\_  
Date Quit \_\_\_\_\_

**ALCOHOL HISTORY:** No Yes  
How much \_\_\_\_\_  
What kind \_\_\_\_\_

**RECREATIONAL DRUGS OR SUBSTANCES:** No Yes  
How much \_\_\_\_\_  
What kind \_\_\_\_\_

**ALLERGIES: (including drugs, tapes, iodine, latex, etc.)**

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

**LIST OF CURRENT MEDICATIONS (including herbal supplements and vitamins):**

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

**LIST OF PREVIOUS SURGERIES AND DATES:**

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

**I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.**

Signed \_\_\_\_\_ Date \_\_\_\_\_

# Brent A. Rubis, M.D.

Financial Responsibility:

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

Insurance:

All co-pays are due at the time of the appointment. As a convenience to our patients, we will file the remaining balance to your insurance. It is ultimately your responsibility to make sure that your insurance pays. Any remaining balance, after your insurance has paid or denied the bill, you are responsible for. Remaining balances are due in full, unless other arrangements are made, to avoid being sent to the collection agency.

Self-Pay:

All payments are due at the time of service unless other arrangements are made prior to. Payments are to be made monthly and the balance is to be paid in full by the end of 3 months, unless other arrangements are made, to avoid being sent to the collection agency.

Cosmetic:

All fees for cosmetic surgery are due one week prior to surgery. We accept cash, cashier checks, or credit cards. Financing is also available. A nonrefundable deposit is required to schedule surgery. This amount will be forfeited if surgery is canceled within two weeks of the surgery date. If surgery is canceled by the patient within one week of surgery, 100% of the surgeon's fee will be forfeited.

I have read and understand the above statements.

\_\_\_\_\_  
Signature of Patient/Guarantor

\_\_\_\_\_  
Date

- All returned checks will be charged a \$30 service fee.
- We also accept Visa and MasterCard.
- All balances that are not paid on monthly will be charged a \$4 per month billing fee.

## HIPAA

I have received a copy of the HIPAA privacy notice.

\_\_\_\_\_  
Signature of Patient/Guarantor

\_\_\_\_\_  
Date

PATIENT RECORD OF DISCLOSURE

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

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (*PHI*). The individual is also provided the right to request confidential communications or that a communication of *PHI* be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

- |  |  |
|--|--|
| <input type="checkbox"/> Home Telephone<br><input type="checkbox"/> O.K. to leave message with detailed information<br><input type="checkbox"/> Leave message with call-back number only | <input type="checkbox"/> Written Communication<br><input type="checkbox"/> O.K. to mail to my home address<br><input type="checkbox"/> O.K. to mail to my work address<br><input type="checkbox"/> O.K. to fax to this number: _____ |
| <input type="checkbox"/> Work Telephone<br><input type="checkbox"/> O.K. to leave message with detailed information<br><input type="checkbox"/> Leave message with call-back number only | <input type="checkbox"/> Other _____<br>_____  |

\_\_\_\_\_  
Signature of Patient/Guarantor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Birthdate

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for *PHI* to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

**Office Use Only**

Record of Disclosures of Protected Health Information

Date	Disclosed to Whom Address or Fax Number	(1)	Description/Purpose	By Whom Disclosed	(2)	(3)

(1) Check this box if authorized  
 (2) Type key: T=treatment; P=payment information; O=healthcare operations; A=authorization on file; D=discretionary  
 (3) Enter how disclosure was made: F=fax; P=phone; M=mail; O=other