BRENT A. RUBIS, M.D.

PATIENT INFORMATION

PATIENT NAME_____AGE_____BIRTHDATE_____
SOCIAL SECURITY NO._____
ADDRESS_____ CITY_____STATE_____ZIP_____
HOME PHONE_____ WORK PHONE_____
CELL PHONE_____ E-MAIL ADDRESS_____
MAY WE E-MAIL YOU INFORMATIONAL UPDATES/NEWSLETTERS YES_____ NO_____

SINGLE____ MARRIED____ DIVORCED___WIDOWED____
MALE_____ FEMALE_____
EMPLOYER_____ OCCUPATION_____
EMERGENCY CONTACT_____PHONE_____RELATION_____

INSURED OR RESPONSIBLE PARTY

RESPONSIBLE PARTY _____RELATIONSHIP_____
SOCIAL SECURITY NUMBER_____BIRTHDATE_____
ADDRESS_____CITY_____STATE_____ZIP_____
HOME PHONE_____WORK PHONE_____
EMPLOYER_____ OCCUPATION_____

PRIMARY CARE PHYSICIAN_____
PREFERRED PHARMACY_____ Phone number or location_____

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 ORGINIAL. 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

History of MRSA/Staph infection _____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_____

SMOKING HISTORY: No Yes
Number of packs per day_____
Date Quit _____
Electronic Cigarettes No Yes

ALCOHOL HISTORY: No Yes
How much_____
What kind_____

WOMEN ONLY:
Date of last mammogram_____
Previous breast biopsy? No Yes
Number of live births _____
Number of C-Sections _____
Have you breast fed? No Yes
For how long? _____

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 scheduling and booking fee is required to schedule surgery. This amount will be forfeited if surgery is canceled. 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 MasterCard and Discover.
- 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):

□ Home Telephone
- □ O.K. to leave message with detailed information
- □ Leave message with call-back number only

□ Written Communication
- □ O.K. to mail to my home address
- □ O.K. to mail to my work address

□ Work Telephone
- □ O.K. to leave message with detailed information
- □ Leave message with call-back number only

□ E-mail: _____

□ Fax: _____

_____ _____
Signature of Patient/Guarantor Date

_____ _____
Print Name Birthdate

I wish for the following people to have access to my medical/financial information:

Name: _____ Relationship: _____ Birthdate: _____

Name: _____ Relationship: _____ Birthdate: _____

Name: _____ Relationship: _____ Birthdate: _____