

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 TEXT YOU? YES _____ NO _____
MAY WE EMAIL YOU? YES _____ NO _____

SINGLE ___ MARRIED ___ DIVORCED ___ WIDOWED ___
MALE ___ FEMALE ___
EMPLOYER _____ OCCUPATION _____
EMERGENCY CONTACT _____ PHONE _____ RELATION _____

INSURED OR RESPONSIBLE PARTY (not necessary for cosmetic/self-pay patients)

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: _____
Facebook Group: _____ Instagram: _____

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	
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 _____

HAVE YOU EVER TAKEN:

Accutane	No	Yes
Phentermine	No	Yes
Birth Control/Hormone Therapy	No	Yes

SMOKING HISTORY: No Yes

Number of packs per day _____

Date Quit _____

Electronic Cigarettes No Yes

WOMEN ONLY:

Date of last mammogram _____

Previous breast biopsy? No Yes

Number of births _____

Number of c-sections _____

Have you breast fed/how long? No Yes _____

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 treatment.

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, Discover, AMEX and CareCredit
- 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/Cell Telephone | <input type="checkbox"/> Written Communication |
| <input type="checkbox"/> O.K. to leave message with detailed information | <input type="checkbox"/> O.K. to mail to my home address |
| <input type="checkbox"/> Leave message with call-back number only | <input type="checkbox"/> O.K. to mail to my work address |
| <input type="checkbox"/> Work Telephone | <input type="checkbox"/> E-mail: _____ |
| <input type="checkbox"/> O.K. to leave message with detailed information | <input type="checkbox"/> Fax: _____ |
| <input type="checkbox"/> Leave message with call-back number only | |

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: _____