Edward S. Rubin, M.D. PC

Board Certified Anesthesiology & Pain Medicine

410 Lakeville Road Suite 303 New Hyde Park, NY 11042 : Tel 516.492.3100 : Fax 516.492.3097 : www.selectpainconsultants.com

New Patient Information Record

FULL LEGAL NAME

Last Name _______________________ First _______________________ Middle ___________________

Address ___________________________________ City ____________________ State _____ Zip ______

Home telephone (   )______________ Date of Birth ___________________ Sex _____ Age __________

Race _______ Social Security # _________________________ Marital Status: M S W D

PATIENT EMPLOYER INFORMATION

[ ] Currently employed [ ] Unemployed [ ] Retired [ ] Legaly disabled

Company Name _______________________________ Address ___________________________________

City ___________________________ State ________ Zip ______ Work telephone (   ) ____________

IF MARRIED, PLEASE LIST SPOUSE'S EMPLOYMENT INFORMATION

Name ____ DOB_______________ SS#_____________

Employer ____

City __________________________ State _______ Zip ________ Telephone # (   ) ______________

NEAREST RELATIVE NOT LIVING AT HOME

Name _________________________ Relationship ________________ Telephone # (   ) _____________

Address ______________________________ City ___________________________ State ____ Zip _____

Referring Doctor __________________________________ Telephone # (   ) _____________________

Doctor's address ____ Suite # ____________________

City ____________________________ State ________ Zip ____________

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PRIMARY CARE PHYSICIAN ______________________Telephone # (   ) ____________

Address ___________________________Suite:__________

City ______________________State _________ Zip ______________

PRIMARY INSURANCE

Insurance Company ____________________________ Cardholder's Name ______________

Policy # __________________________________ Group # ______________________

PRIMARY CARDHOLDER INFORMATION (If different from patient)

Name _____________________ SS# ___________ Relationship ____________________

SECONDARY INSURANCE COMPANY

Insurance Company ____________________________ Cardholder's Name ______________

Policy # ___________________________________ Group # _____________________

WORKER'S COMPENSATION INFORMATION / NO - FAULT INSURANCE

Date of Injury _____________ Claim # _____________ Ins. Carrier __________________

Address _________________________ City __________________ State ___ Zip _____

Telephone # (   ) ___________ Adjuster _______________________________________

Employer at time of injury ___________________ Last Day Worked______________

Employer's address at time of injury ____

Description of accident ____

Treating MD _________________ Address ___________________________________

City ________________ State _______ Zip _______ Telephone # (   ) ______________

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Circle One

Y N **INSURANCE AUTHORIZATION**
I hereby authorize Enter Name Here to furnish information to my insurance carriers concerning my illness and treatment.

Y N **ASSIGNMENT OF BENEFITS**
I hereby assign to Edward S Rubin, MD PC all payments for medical services rendered to my dependents or myself. I understand that I am responsible for any amount not covered by insurance.

Y N **TREATMENT AUTHORIZATION**
I hereby authorize Edward S Rubin, MD PC to render health care to me during my visit.

Y N **PRIVACY NOTICE**
I have received a Notice from Edward S Rubin, MD PC that explains how my personal health information will be used

Signature ____ Date ____________________