

Rubin Orthopedics
NEW PATIENT REGISTRATION

Patient Name	Date of Birth	M / F
SSN:	Marital Status: Single / Married / Divorce / Widowed	
Email:		
ADDRESS:	CITY:	ZIP:
Home Tel #:	Cell #:	

Occupation:	Employer:
Address:	
City/ST/Zip:	
Work Tel #:	EXT:

Insurance Guarantor/Subscriber Information

Name:
Address:
City/ST/Zip
Relation to Patient

(Only fill out if patient is a minor)

Mother's Name:	Father's Name:
SSN:	SSN:
Date of Birth:	Date of Birth:/
Address:	Address:
City/ST/Zip:	City/ST/Zip:
Home Tel #:	Home Tel #:
Cell #:	Cell #:
Occupation:	Occupation:
Employer:	Employer

Insurance Information

Primary Ins:	Secondary Ins:
ID#:	ID#:
Group #:	Group #:
Primary Care Physician:	Primary Care Physician:
Phone #:	Phone #:

Patient/Parent/Guardian Signature: _____

Date: _____

RUBIN ORTHOPEDICS HISTORY FORM

Today's Date: _____ Patient Name: _____

Date of Birth: _____ M / F Height: _____ Weight: _____

Left / Right Handed (please circle one)

Primary Care Physician: _____ Phone # _____

Referring Provider name and Phone # (if different than PCP): _____

How did you hear about our office? (patient, physician, newspaper, website): _____

What is the main reason for your visit today? _____

Date of accident or date your symptoms began: _____

Did you have an injury or accident? If yes, please describe: _____

List any other doctors you have seen for this problem: _____

Are you getting? (Please Circle) Better Worse No Change

If you have pain, how severe is it on a scale from 1 to 10 (10 being unbearable) 1 2 3 4 5 6 7 8 9 10

Is the pain everyday? YES / NO Does the pain wake you up at night? YES / NO

What makes your pain better? _____ Worse? _____

If surgery might alleviate your pain, would you be interested in having surgery? YES / NO

Have you had any X-rays or other imaging studies? Y / N

If yes, what was imaged ? (neck, arm, shoulder): _____

When and where studies performed? _____

Treatments/Tests that you have tried (Please check the appropriate one):

Physical Therapy: _____ How many visits: _____ Braces: _____ Surgery: _____ Injections: _____

Chiropractor: _____ Acupuncture: _____ Massage: _____ Did these treatments help? YES/ NO

*****Birth History (Complete this portion ONLY if patient is a minor)**

Full Term? _____ If premature, how many weeks?: _____
Problems at birth?: _____
How is your child doing in school? Fair / Average / Above Average (please circle one)
My child attends: Regular School: _____ or Special Ed: _____
Immunization up to date? _____

MEDICAL HISTORY

Do you have any major medical problems (high blood pressure, high cholesterol, diabetes, cancer, etc)? Please describe:

Allergies to medications: _____

Other allergies: _____

PAST OPERATIONS OR HOSPITALIZATIONS	
Type of Surgery/Hospitalization	Date

FAMILY HISTORY

Type of Illness	Yes	Relative (i.e. aunt, sister, cousin, dad)	Type of Illness	Yes	Relative (i.e. aunt, sister, cousin, dad)
Diabetes			Drinking Problem		
Stroke			Breast Cancer		
Heart Disease			Colon Cancer		
High Blood Pressure			Ovarian Cancer		

SOCIAL HISTORY				
Do you smoke?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Cigarettes per day _____	Per week _____
Do you drink alcohol?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Drinks per day _____	Drinks per week _____
Use drugs?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, what kind? _____	
Regular Exercise	Yes <input type="checkbox"/>	No <input type="checkbox"/>	What sports do you play? _____	Level played? (please circle) Recreational/ school/semi-pro/ professional
Are you disabled?	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
If yes, please explain why: _____				

Marital Status:	Married <input type="checkbox"/>	Single <input type="checkbox"/>	Widowed <input type="checkbox"/>	Divorced <input type="checkbox"/>
Number of people in household (please include children) : _____				
List names of people who live in your household, their age, and relation to you:				
Name	Age	Relation to you	Occupation	
Who should be contacted in case of emergency? _____ Relationship to you? _____				
Phone # _____				

What level of education have you have completed: (please check if completed)

High School: _____ Name of school: _____

College: _____ Name of School: _____ Degree earned: _____

Graduate Degree: _____ Name of School: _____ Degree earned: _____

Other: (please explain) _____

Are you currently employed? Y / N

Are you currently working? Y / N

What is title of your job position? _____

Name of company: _____

How long have you been at current position? _____

What was your previous job position? _____

What kind of physical activity is associated with your job? (desk work, heavy lifting, walking, bending, etc.)

Patient or Guardian Signature: _____

Date: _____

Patient Consent for use and disclosure of protected health information

With my consent, the office of Roy M. Rubin, MD, Inc may use and disclose protected health information (PHI) about me/my child to carry out treatment, payment and healthcare operations (HOP). Please refer to Roy M. Rubin, MD, Inc's Notice of Privacy Practices for a more complete description of such use and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Roy M. Rubin, MD, Inc reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practice may be obtained by forwarding a written request to: Privacy Officer, Roy M. Rubin, MD, 500 University Ave, Suite # 100 Sacramento, CA 95825

With my consent, the office of Roy M. Rubin, MD may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out HOP, such as appointment reminders, insurance items or any call pertaining to my clinical care, including laboratory results among others.

I authorize any holder of medical information about me to release information to any of the following: My insurance company, the social security administration, and/or Medicare program or its intermediaries or carriers, and/or the professional review organization. This includes information needed for processing and payment of insurance claims.

With my consent, the office of Roy M. Rubin, MD, Inc may take my/my child's photo for in-take purposes. This photo will only be used in my/my child's medical file and will not be distributed or displayed elsewhere without my prior consent. Photographs are used by medical office for familiarity and recognition of myself and/or my child by Roy M Rubin, MD, Inc as they care for patients.

With my consent, the office of Roy M. Rubin, MD may mail to my home or other designated location any items that assist the practice in carrying out HOP, such as appointment reminders and patient statements. I have the right to request that the office of Roy M. Rubin, MD restrict how it uses or discloses my PHI to carry out HOP. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Roy M. Rubin, MD Inc the use and disclosure of my protected health information to carry out treatment, payment and health operations. This is a life time authorization.

_____ (Patient/Guardian initials)

Financial Agreement

"I, the undersigned, have insurance coverage with _____ (name of insurance company) and assign directly to Dr. Roy M. Rubin, all medical benefits, if any, otherwise payable to me for services rendered. This assignment will remain in effect until revoked by me in writing. **I understand that I am financially responsible for all charges whether or not paid by insurance.** I hereby authorize the doctor to release all information necessary to secure the payment for services. I authorize Roy M Rubin, MD, Inc to perform any medical treatment as deemed medically necessary and appropriate. I authorize the use of this signature on all my insurance submissions."

Print Patient Name

Signature of Patient or Legal Guardian

Print Name of Legal Guardian (if applicable)

Date