Edward S. Rubin M.D. 1991 Marcus Avenue Ste M217 Lake Success, NY 11042
Phone: 516-492-3100 Fax: 516-492-3097

Full Legal Name

Last Name:__________________________ First Name:__________________ DOB:____________________

Address:______________________________City_____________________State________ Zip___________

Home Phone#:__________________ Work#:_____________________ Cell#:__________________________

SS#:______________________ Marital Status:__________________

Patient Employer Info: ( ) currently Employed ( ) Unemployed ( ) Retired ( ) Legally Disabled

Employer Name:____________________________ Position:________________________

Address:____

Phone#:____________________________

Nearest Relative for Emergency Contact:

Name:___________________________________ Phone#__________________________

Address:____

Referring Doctor:

Name:____________________________________ Phone:________________________________

Address:____

Primary Doctor:

Name:____________________________________ Phone:________________________________

Address:____

Primary Insurance:

Insurance Company:___________________________________ Phone#:_______________________

Address:____

Policy #:__________________________Group#_________________________

Card Holder Name:____ DOB:___________ SS#_____________________

Does your Ins. policy require a referral/authorization from your primary doctor to see a specialist: YES NO

Secondary Insurance:

Insurance Company:__________________________________ Phone#:______________________

Address:____

Policy #:_________________________Group#________________________

Card Holder Name:______________________________________ DOB:___________ SS#____________________

Workers Comp Information: Only if you were injured at work & have filed a claim with your employer.

Date of Injury:________________

Ins Carrier:____________________________________ Phone#_______________________________

Address:____________________________________ City_______________________ State______ Zip__________

WC Claim#______________________ WCB#_________________________

Adjuster:______________________________________ Phone#_______________________________

Employer at time of Accident:____

Address:__________________________________City____________________State_____________Zip________

Job Title:_____________________ Job Description:____

Description of Accident:____

____.

Injured Body Part(s) filed on Workers Compensation Claim with your employer:

____

No Fault Ins. Information: (Only if you were involved in a motor vehicle accident)

Date of Injury:________________ NFClaim#______________________

Ins Carrier:____________________________________ Phone#_______________________________

Address:____________________________________ City_______________________ State______ Zip__________

Adjuster:______________________________________ Phone#_______________________________

Description of Accident:____

____.

Injured Body Part(s) reported with your Auto Insurance Company:

____

Circle One

Y N **INSURANCE AUTHORIZATION**
I hereby authorize Dr. Edward S. Rubin to furnish information to my insurance carriers concerning my illness and treatment.

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

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

Y N **PRIVACY NOTICE**
I have received a notice from Dr. Edward S. Rubin that explains how my personal health information will be used.

If your insurance carrier requires you to have a referral generated by your PCP, to see a specialist, it is your responsibility to provide the referral to Dr. Rubin's office the day of your initial visit as well as follow-up visits. Please be advised if a referral is not provided you will be responsible for full payment of services rendered.

Copayments are due at the time of service or a $25.00 fee will be charged.

I _______________________________ hereby acknowledge the above statement and agree to adhere to the referral guidelines or accept responsibility for payment.

Signature______________________________________ Date_____________________