# Central Florida Hand Specialists

Jerry A. Rubin, M.D.
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## Personal Information

First name: Middle name: Last name:

Date of birth: SSN Sex Select One

Address 1: Address2:

City: State Select One Zip code:

Country Select One email address:

Home phone: Cell phone: Work phone:

Employed by:

Employers address: City: State Select One Zip code:

Occupation: Drivers License (State) #

## Responsible Party Information-Parent or Legal Guardian

Name: Relation:

Date of birth: SSN Phone Number:

## Insurance Information

Primary Insurance Company Policy#

Group # Primary Cardholder

Relation to Patient: Date of birth: SSN

Primary Cardholder Employer:

Secondary Insurance Company: Policy#

Group # Primary Cardholder

Relation to Patient: Date of birth: SSN

Primary Cardholder Employer:

## Emergency Contact

Name: _____ Relation: _____

Phone Number: _____

## Credit Policy

Patients (or person financially responsible for the patient) are responsible for payment of their account within the limit of our credit policy. All service are charged directly to the patient and each patient is directly responsible for payment regardless of any insurance coverage. We do not accept any responsibility for collecting, the insurance claim or for any negotiation of a settlement on a disputed claim. THIS IS THE PATIENT RESPONSIBILITY. Payment of office services (including co-pays and deductibles) are due at time the service is rendered. Any other arrangement must be made in advance.

## Authorization

I hereby authorize any physician or hospital who has treated me in the past to release a copy of my records to Jerry A Rubin M.D, P.A. I also authorize Jerry A Rubin M.D, P.A. to release any information in the course of my treatment to (insurance companies, Attorney, Other Physician).

Date: _____ _____

Signature

I authorize, assign and direct you to pay without further notice from me to Jerry A Rubin M.D, P.A such amount as may be payable to me for medical and or surgical treatment.

Date: _____ _____

Signature

## Medical History

Hand Dominance: Select One  Height (inches)  Weight (pounds)

Race: Select One  Marrital Status: Select One  Smoke: Select One  Packs: Select One

Alcohol: Select One  Drugs: Select One

Allergies:

- ◯ No Known Allergies
- ◯ Penicillin
- ◯ Codeine
- ◯ Latex
- ◯ Aspirin
- ◯ Iodine
- ◯ Adhesive tape
- ◯ Other

Medications:

| Name | Dose | Frequency |
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| Name | Dose | Frequency |
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Surgery:

| Year | Procedure |
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| Year | Procedure |
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Systems Review:

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| ◯ Poor Vision | ◯ Burning with urination | ◯ Hearing loss | ◯ Anxiety |
| ◯ Depression | ◯ Rash | ◯ Hoarseness | ◯ Poor Balance |
| ◯ Nosebleeds | ◯ Cough | ◯ Shortness of breath | ◯ Frequent Falls |
| ◯ Chest pain | ◯ Chills/Fever | ◯ Dizziness | ◯ Abnormal Heart Beat |
| ◯ Calf Cramps | ◯ Poor Appetite | ◯ Nausea/vomiting | ◯ Fainting |
| ◯ Stomach Pain | ◯ Stomach Ulcer | ◯ Diarrhea | ◯ Constipation |
| ◯ Bleeding After Surgery | ◯ Frequent Urination | ◯ Foot/leg swelling | ◯ Hemorrhoids |

◯ All Negative (None of the above symptoms are present)

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| **Metabolic Disease** | | | **Cardiac** | | | **Immunologic** | | |
| Diabetes | ◯ | ◯ | High Blood Pressure | ◯ | ◯ | Infection following surgery | ◯ | ◯ |
| Thyroid Disease | ◯ | ◯ | Heart Attack | ◯ | ◯ | Osteomyelitis | ◯ | ◯ |
| Osteoporosis | ◯ | ◯ | Angina | ◯ | ◯ | Immune Disorder | ◯ | ◯ |
| **Pulmonary** | | | Heart Murmur | ◯ | ◯ | **General** | | |
| Asthma | ◯ | ◯ | Arrythmia | ◯ | ◯ | HIV | ◯ | ◯ |
| COPD | ◯ | ◯ | Valve Problems | ◯ | ◯ | Alcoholism | ◯ | ◯ |
| TB | ◯ | ◯ | **GI** | | | Deep venous thrombosis | ◯ | ◯ |
| **Neurologic** | | | Ulcer | ◯ | ◯ | Mental Illness | ◯ | ◯ |
| Stroke | ◯ | ◯ | Gall Bladder | ◯ | ◯ | **Cancer** | | |
| Seizure | ◯ | ◯ | Hiatal Hernia | ◯ | ◯ | Type: | | |
| Closed Head Injury | ◯ | ◯ | GI Bleeding | ◯ | ◯ | Year Diagnosed: | | |
| Concussion | ◯ | ◯ | Liver Disease | ◯ | ◯ | Treatment: | | |
| **Arthritis** | | | **Blood Disorder** | | | | | |
| Rheumatoid | ◯ | ◯ | Anemia | ◯ | ◯ | | | |
| Lupus | ◯ | ◯ | Clotting Disorder | ◯ | ◯ | | | |
| Gout | ◯ | ◯ | Family history of clotting disorder | ◯ | ◯ | | | |
| Lyme's Disease | ◯ | ◯ | Sickle Cell Disease | ◯ | ◯ | | | |
| Osteoarthritis | ◯ | ◯ | | | | | | |

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Patient Name: Date of Birth:

Please describe the injury or problems you may be experiencing

Please give a detailed description of how the accident happened

Please describe your current symptoms

Where did your injury happen? Select One

**Primary Care Physician**

Name: Phone Number

Fax Number: Do you want your records faxed to your primary? ◯ Yes ◯ No

Address:

**Referral Information**

Referred By: Phone Number Fax Number:

**Pharmacy Information**

Name: Phone Number Fax Number:

Zip code: Intersection Streets: