



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 _____