Joshua S. Rubin DDS PLLC

Patient Information

Patient Name: _____ Gender: _____
Last, First, MI (Preferred Name)

Social Security #:_____ Birth Date:_____ Family Status _____

☐ ☐

Phone: (Primary) _____ (Secondary) Work/Cell _____ email: _____

Address: _____.
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

☐ HIV
☐ Allergies
_____
_____
_____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes

☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure

☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Pregnant
Due date:_____
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism

☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease

OTHER:
☐ _____
☐ _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Please list all medications currently taking:_____

_____

- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

To the best of my knowledge, all responses and information provided are accurate. If any conditions change, I will inform the doctors at my next appointment.

Patients/guardian signature_____Date_____

Doctor's signature_____Date_____

Referral Information
Whom may we thank for referring you to our practice? _____
You may choose one of the following: Internet, Insurance, Colleague Employer/ Provider

Insurance Information

Primary Insurance:

Name of Insured: _____ is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

Secondary Insurance (if applicable)

Name of Insured: _____ is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

Consent for Services

This office will help prepare insurance forms and assist in collecting payments from your insurance company. **We do not warrant their expected payment or coverage. Patients are responsible for all charges**. We will do everything possible to see that you receive the full benefits of your policy.

I understand that the fee estimate listed for my treatment plan is only valid for six months from the date of my examination.

I grant permission to telephone me to discuss matters related to my account.

Your appointment is time that has been reserved especially for you--we strongly encourage all patients to keep their appointments. **If you must change or cancel your appointment, we require at least 24 hours notice to avoid a $100.00 cancellation fee**

Unless you give us a written authorization, we cannot release your health information.

I understand the above conditions of treatment and payment, and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

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Acknowledgement of Receipt of Notice of Privacy Practices (HIPAA)

I have **received** a copy of the Notice of Privacy Practices.

_____

Please print patient's name

_____

Patient's/guardian's signature

_____

Date