



Today's Date _____

Patient Name _____ Gender M F
Last First Middle

Date of Birth (MM/DD/YYYY) ____/____/____ Age ____ Social Security Number ____--____--____

Family Doctor _____ Office Number _____

Referring Doctor _____ Office Number _____

Marital Status _____

Address _____ Home Phone _____

_____ Cell Phone _____

Employer _____

Work Number _____ Email _____

Emergency Contact

Name _____ Relationship _____ Phone Number _____

Insurance Information (Insurance Company, Policy Number, Contact Number)

Insurance Carrier _____ Contact # _____

Policy # _____ Policy Holder _____

Group # _____ Relationship _____

Subscriber Information SS# ____--____--____ DOB _____

Employer _____ Employer Address _____

Additional, or Secondary Insurance Company

Insurance Carrier _____ Contact # _____

Policy # _____ Policy Holder _____

Group # _____ Relationship _____

Subscriber Information SS# ____--____--____ DOB _____

Employer _____ Employer Address _____

The above information is true to the best of my knowledge. I hereby authorize Harvey A. Rubenstein, MD, PC, Frank R. Crantz, MD and S. Mark Tanen, MD, LLC to apply for benefits on my behalf (or my child's) for services rendered. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor. I authorize release of any information concerning my health care, advice and treatment provided for the purposes of evaluation and administering claims for insurance benefits. In compliance with state regulation records are retained for 6 (six) years after the first date of service.

Patient/Guardian Signature _____ Date _____



Name: _____

Why are you seeing the doctor?:

Please list all your medications, with dosage if known (include over-the-counter medications):

Please list any drug allergies or adverse reactions to medications:

Personal History:

What is your current occupation?: _____

Place of birth: _____

Do you smoke? _____ If yes, how much? _____ If quit, when? _____

Do you drink alcohol? _____ If yes, how much? _____

Number of pregnancies? _____ Number of children? _____

Past Medical History:

Please list all operations, with year of surgery:

Please list any other hospitalizations or ongoing medical problems:

Family Medical History:

Please list any family members with the following:

Cancer _____ Diabetes _____

Heart Disease _____ Osteoporosis _____

Thyroid Disease _____ Hypertension _____

Other (Adrenal, Parathyroid, Pituitary, etc.) _____



REVIEW OF SYSTEMS. PLEASE COMPLETE IF ANY ARE POSITIVE:

RECENT SKIN PROBLEMS? _____
RECENT CHANGE IN YOUR HAIR? _____
DO YOU PERSPIRE EXCESSIVELY? _____
CHANGE IN SKIN COLOR? _____

RECENT CHANGE IN VISION? _____
DO YOU GET HEADACHES MORE OFTEN THAN OTHERS? _____
ANY OTHER DIFFICULTIES WITH YOUR EYES? _____
PROBLEMS WITH YOUR EARS OR HEARING? _____
PROBLEMS WITH YOUR TEETH OR GUMS? _____

FREQUENT OR SEVERE SORE THROAT? _____
ARE YOU SUBJECT TO HOARSENESS? _____
DO YOU HAVE DIFFICULTY SWALLOWING? _____

DOES HOT OR COLD WEATHER BOTHER YOU MORE THAN OTHERS? _____
HAVE YOU EVER BEEN TOLD OF A THYROID PROBLEM? _____
HAVE YOU EVER HAD ANY THERAPEUTIC RADIATION TO YOUR HEAD OR NECK
(NOT INCLUDING ROUTINE DIAGNOSTIC X-RAY STUDIES)? _____

DO YOU HAVE A CHRONIC COUGH? _____
ANY BREATHING OR LUNG PROBLEMS? _____
ANY HISTORY OF HEART DISEASE OR HIGH BLOOD PRESSURE? _____
DO YOU HAVE SIGNIFICANT SWELLING OF YOUR ANKLES? _____
DO YOU NOTICE AN IRREGULAR HEART BEAT OR PALPITATIONS? _____

ANY SIGNIFICANT CHANGE IN APPETITE? _____
DO YOU HAVE FREQUENT INDIGESTION? _____
ANY CHANGE IN PATTERN OF BOWEL MOVEMENTS? _____
ANY RECENT WEIGHT CHANGES? _____

HOW OFTEN DO YOU AWAKEN FROM SLEEP TO URINATE? _____
HAVE YOU EVER HAD KIDNEY STONES? _____
ANY HISTORY OF KIDNEY PROBLEMS? _____

ANY JOINT OR MUSCLE PROBLEMS? _____
ANY NEUROLOGIC PROBLEMS? _____
ANY TINGLING OR NUMBNESS? _____
PROBLEMS WITH HEADACHES? _____
EPISODES OF LIGHTEADEDNESS OR DIZZINESS? _____

*******WOMEN*******

ARE YOUR PERIODS FREQUENTLY IRREGULAR? _____
ANY HOT FLASHES OR OTHER MENOPAUSAL SYMPTOMS? _____
ANY DISCHARGE FROM THE BREASTS? _____

*******MEN*******

ANY DIFFICULTY GETTING OR MAINTAINING AN ERECTION? _____
ANY HISTORY OF A PROSTATE DISORDER? _____
ANY TESTICULAR PAIN OR SWELLING? _____



HARVEY A. RUBENSTEIN, MD, PC
FRANK R. CRANTZ MD
S. MARK TANEN, MD, LLC

DIPLOMATES OF THE AMERICAN BOARD OF INTERNAL MEDICINE
DIPLOMATES OF THE SUBSPECIALTY BOARD OF ENDOCRINOLOGY AND METABOLISM

Consent Agreement

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that health care providers provide a Privacy Notice and, optionally, may require a signed Authorization as it relates to the use and disclosure of individually identifiable health information (IIHI). This allows IIHI to be used or disclosed for treatment, payment and other health care operations (TPO) purposes only, unless the patient specifically denies authorization.

Though not necessary to have your consent to allow us to use or disclose your IIHI to others who will treat you or support in providing you quality health care services, it is important to have you consent to use or disclose your IIHI to health care plans to insure accurate and timely payments for the services rendered. The law requires that we inform you of our policy regarding the protection of your IIHI and to provide you with our Privacy Notice. We may already have a consent agreement from you, but under the new Privacy Standard, we are required to provide our Privacy Notice that specifically addresses the use or disclosure of your IIHI. Please refer to our Privacy Notice for a full explanation of how this office will protect your individually identifiable health information (IIHI).

Thank you for your continued confidence in our practice and for supporting our new requirements.

The following is a statement that allows us the necessary latitude to work within the new requirements.

I, _____, have been presented with a Privacy Notice explaining my rights regarding my IIHI. I consent to the use and/or disclosure of my IIHI for the purposes of treatment, payment or other health care operations (TPO). Other uses of my IIHI will require an authorization from me for the specific intention of disclosure.

Patient: _____

Date: _____