New Patient Registration Renee Rubinstein MD

Name________________________________Address___________________________________

City and Zip Code____

Email________________________________SS#______________________________________

DOB___________________Age_______________Cell Phone___________________________

Insurance____________________________Policy number_____________________________

Policy Holder__________________________Employer__________________________________

Emergency Contact____

Medical Problems____

____

____

Family hx____

Surgeries & dates____

____

____

Medicines & doses____

____

____**Allergies**______________________________

Pharmacy (name,address,phone)____

Do you smoke____________How many years______________Do you want to quit__________

Do you drink______ How much___________________________Do you want to quit_________

Do you feel you are dependent on any of your meds?____________Do you want help to get off

of any?____

I certify that I have received a copy of Renee Rubinstein MD ***Notice of Privacy Practices***

*(sign here)*____