MARIO RUB, M.D 20776 WEST DIXIE HWY, AVENTURA FL 33180, 305-931-1812 **DATE :__/___/____**

APPT DATE: _____/____/_____ TIME:_____ AVENTURA/PINES/PALMETTO

REASON FOR REFERRAL: Urgent ( )

_____

_____

LAST:_____ FIRST:_____

DOB: _____-_____-____ SEX : male female lgbt

ADDRESS:_____

City:_____State: FL____Zip:_____ email:_____

Phone: ( )-_____-_____ race : _____

Insurance:_____

Policy#:_____Group_____

AUTHORIZATION:_____ Effective DATE:_____

Date_____ Copay_____ DEDUCTIBLE: _____ need referral___YES ___ NO ___

Ref. provider: Last:_____First_____npi_____

Address:_____

Phone:_____fax_____

HOSPITALIZATION (Emergency): YES( ) NO ( )

_____

_____

PHARMACY: CVS WALG W-MART PUBLIX ZIPCODE :_____

Synagis: yes( ) no ( ) preemie less than 30 week(yes) no EGA:_____weeks

NICU discharge yes( ) no( ) family history: asthma heart disease, preschool children smoker

Seen by other pulmonologist allergist

Allergies:_____

NAME PERSON FILLING

INFO:_____