Welcome to the Rubin Institute for Advanced Orthopedics!

Dear New Patient,

Welcome to the Rubin Institute for Advanced Orthopedics! Our goal is to provide you with caring, compassionate and professional service during your visit with us. If you have any questions, you can visit our web site at www.RubinInstitute.com or you can call us at 410-601-BONE (2663).

- Please complete the enclosed Pre-Visit Checklist before your appointment. This checklist tells you what you need to do before your appointment and what you need to bring to your appointment.

- Please arrive 20 minutes before your scheduled appointment to allow us time to process your insurance and billing information.

- A parent or legal guardian must accompany all children (younger than 18 years) for the entire visit.

- A legal representative must accompany all patients who lack the capacity to make health care decisions or who are unable to articulate their wishes.

- If your appointment is in the Schoeneman Building at Sinai Hospital, you will receive two bills: one from the physician and one from the hospital.

We reserve the right to reschedule your appointment if:

- You are more than 15 minutes late for your appointment. If you are going to be more than 15 minutes late, call 410-601-BONE (2663) (press option 1).

- You do not fax your Referral/Authorization (if required by your insurance) at least 5 business days before your appointment. Please contact your insurance company to find out if you need a Referral/Authorization.

- If your insurance requires that your x-rays be taken at an outside facility, but you have forgotten to bring these x-rays with you.

Thank you for choosing the Rubin Institute for your orthopedic care. We are looking forward to seeing you soon!

–The Physicians and Staff of the Rubin Institute
Pre-Visit Checklist

BEFORE YOUR APPOINTMENT, PLEASE:

- Fax your Referral/Authorization (if required) to 410-601-8793 at least 5 days before your appointment. To find out whether you need a Referral/Authorization, please call your insurance company. The Referral/Authorization should be from your primary care physician and authorize Sinai Hospital/Rubin Institute for your office visit, radiology exams, procedures, injections and lab work.

- If an Urgent Care Center advised you to visit the Rubin Institute, please obtain a Referral/Authorization from your primary care physician.

- If your insurance requires that your x-rays, MRI scan or CT scan be obtained at an outside facility, make sure that you have these taken before your appointment and bring the images with you. To find out whether you need to obtain these at an outside facility, please call your insurance company.

- Allow enough time so that you arrive 20 minutes before your scheduled appointment. If you are going to be more than 15 minutes late, call (410) 601-2663 (press option 1).

PLEASE BRING THE FOLLOWING ITEMS TO YOUR APPOINTMENT:

- All forms included in this packet (Please complete the forms before your appointment if possible.)
- Current medical and prescription insurance card(s)
- Valid photo ID or driver’s license
- Payment for any required co-payments or deductibles due at the time of your visit
- Recent x-rays, MRI scans and CT scans: If your insurance requires that your x-rays, MRI scan or CT scan be obtained at an outside facility, bring the images with you. Note: If your insurance allows x-rays to be obtained at the Rubin Institute, we will obtain them during your appointment.

- If an Urgent Care Center advised you to visit the Rubin Institute, please bring a Referral/Authorization from your primary care physician.

- Any medical information that is relevant to your condition (x-rays, CT scans, MRI scans, ultrasound results, nerve conduction studies, medical records, lab results, etc.)

- List of current medications (vitamins, supplements, over the counter medications, prescription medications, herbal supplements, etc.) including strength, frequency and dose

- List of allergies to medications, food, metal, latex, etc.

- Name, address, phone number and fax number for your pharmacy, referring physician, primary care physician and anyone else whom you would like to receive your medical information.
# Patient Registration Form

**PLEASE PRINT LEGIBLY**

Date: ____________________

Patient’s Name: ____________________  Last  ____________  First  ____________  Middle Initial

Date of Birth (MM/DD/YYYY): ____________________  Sex:  ☐ Male  ☐ Female

Patient’s Address: ____________________

Street ____________________

City ____________________  State ____________________  Zip Code ____________________

E-mail Address: ____________________

Phone:  Home: ____________________  Work: ____________________  Cell: ____________________

Do you have a living will (advance health care directive)?  ☐ Yes  ☐ No

Would you like to receive information about creating a living will?  ☐ Yes  ☐ No

If the patient is a minor (younger than 18 years), who is accompanying the child today?

Name: ____________________  Relationship: ____________________

Do you have custody of this child?  ☐ Yes  ☐ No

**CONTACT INFORMATION FOR YOUR OTHER DOCTORS:**

Primary Care Physician’s Name: ____________________

Address: ____________________  Street ____________________  City ____________________  State ____________________  Zip Code ____________________

Phone: ____________________  Fax: ____________________

Referring Physician’s Name (Doctor Who Sent You Here)

Name: ____________________  Doctor’s Specialty: ____________________

Address: ____________________  Street ____________________  City ____________________  State ____________________  Zip Code ____________________

Phone: ____________________  Fax: ____________________

Other Specialist (Neurologist, Pain Specialist, Cardiologist, etc.)

Name: ____________________  Doctor’s Specialty: ____________________

Address: ____________________  Street ____________________  City ____________________  State ____________________  Zip Code ____________________

Phone: ____________________  Fax: ____________________
Health Summary Form for Pediatric Patients

Date: ____________________________

Child's Name: ___________________ Last ____________________ First ____________________ Middle Initial ____________________

Date of Birth (MM/DD/YYYY): ____________________ Age: ________ Height: ________ Weight: ________

Sex: ☐ Male ☐ Female Child is: ☐ Right handed ☐ Left handed ☐ Ambidextrous

LIVING SITUATION:
Parent/s' Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Other: ______________________________

Mother's Occupation: ______________________________ Father's Occupation: ______________________________

The child lives with: ☐ Family ☐ Guardian ☐ Care facility ☐ Group home

SYMPTOMS:
Circle the part of the body that is bothering the child.

Reason for your visit: ____________________________________________________________

Symptoms started because of: ☐ Spontaneously ☐ Fracture/break ☐ Twisting injury ☐ Fall/sports injury
☐ Motor vehicle accident - Date of accident: ______________________________
☐ Other: __________________________________________________________

When did the symptoms first begin (date or year)? ______________________________

When did the symptoms get worse (date or year)? ______________________________

Symptoms include: ☐ Weakness ☐ Swelling ☐ Numbness/tingling

HISTORY OF TREATMENT FOR THIS PROBLEM:
What other treatments have you tried for this problem (check all that apply)? ☐ None ☐ Heat or cold therapy ☐ Narcotic medications
☐ Advil, Motrin, ibuprofen, Aleve, Aspirin, etc.
☐ Brace/Orthotic How long? _________________ Type: _________________
☐ Physical therapy ___________ times per week for ___________ months

SOCIAL INFORMATION:
Grade in School (if applicable): ____________________ Sports/Hobbies: ____________________ Pets: ☐ Yes ☐ No

Does the child use tobacco, alcohol, or recreational/street drugs? ☐ Yes ☐ No

DESCRIBE THE PAIN: Mark an “X” on the line to show the child’s level of pain.

Rate pain during activity: _______________ Rate pain at rest: _______________

What makes the pain worse? ____________________________________________

What makes the pain better? ____________________________________________
**CHILD’S BIRTH AND DEVELOPMENTAL MILESTONES:**

This child was born:  □ Early (less than 37 weeks)  □ Term  □ Late (more than 42 weeks)

Delivery was:  □ Vaginal  □ Breach  □ C-section  

Birth weight: ___________ lbs ___________ oz

Rolled over at age: __________  Crawled at age: __________  Sat alone at age: __________  Walked at age: __________

At what age (if applicable) did the child experience her first menstrual period? __________

**MEDICAL HISTORY:**  Please provide information about surgeries and serious illnesses that required hospitalization.

<table>
<thead>
<tr>
<th>Date of Surgery/Illness</th>
<th>Type of Surgery or Illness</th>
<th>Reason for Surgery or Hospitalization</th>
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Attach additional pages if necessary

**PRIOR CONDITIONS/PROCEDURES (CHECK ALL THAT APPLY):**

**Cardiovascular**
- □ None
- □ High blood pressure
- □ Irregular heart beat
- □ Valve disease
- □ Cardiac surgery
- □ Heart murmur
- □ Peripheral vascular disease (poor circulation)

**Hematologic**
- □ None
- □ Sickle cell disease/trait
- □ Blood clotting problems
- □ Anemia/Low blood count
- □ AIDS/HIV
- □ Previous blood transfusion
- □ Chemotherapy

**Pulmonary**
- □ None
- □ Asthma
- □ Sleep apnea
- □ Tuberculosis

**Cancer**
- □ None
- □ Type: ________________

**Neurologic/Psychiatric**
- □ None
- □ Stroke/TIA
- □ Head injury
- □ Seizures
- □ Cerebral palsy
- □ Paralysis
- □ Autism
- □ ADHD/ADD
- □ Developmental delay
- □ Depression/Angiety

**Anesthesia**
- □ None
- □ Family history of problems
- □ Previous complications

**Musculoskeletal**
- □ None
- □ Rheumatoid arthritis
- □ Neuromuscular disease
- □ Muscular dystrophy
- □ Joint infection
- □ Scoliosis
- □ Osteonecrosis/AVN
- □ Lyme disease
- □ Multiple bone fractures

**Skin/Integumentary**
- □ None
- □ Rashes or lesions
- □ Psoriasis/Eczema
- □ Sores/Ulcers

**Renal/Endocrine/GU**
- □ None
- □ Thyroid disease
- □ Diabetes
- □ Obesity
- □ Kidney problems
- □ Recent steroid use
- □ Lupus (SLE)

**Gastrointestinal System**
- □ None
- □ GERD (heartburn and reflux)
- □ Ulcer (stomach or intestine)
- □ Constipation or diarrhea
- □ Hepatitis

**Eyes/Ears/Nose/Mouth/Throat**
- □ None
- □ Recurrent ear infections
- □ Hearing loss
- □ Vision impairment

Does the child have any other conditions that are not listed above? ________________________________
MEDICATIONS, ALLERGIES, AND IMMUNIZATIONS:

Medications include:
- Supplements
- Vitamins
- Prescription medications
- Herbal supplements
- Over the counter medication

☐ My child is not currently taking any medications.

<table>
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<tr>
<th>Medication name</th>
<th>Dose (e.g., strength, number of pills)</th>
<th>Route (e.g., by mouth, inhaled, on skin)</th>
<th>How often does your child take this medication?</th>
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Pharmacy
Name: ____________________________
Phone: ____________________________ Fax: ____________________________

ALLERGIC TO:
- Penicillin
- Latex
- Metal
- Aspirin
- Codeine
- Local Anesthetic
- Food: ____________________________
- None

Other Medication Allergies/Adverse Reactions: ____________________________________________

__________________________________________________________________________________

__________________________________________

Other Allergies/Adverse Reactions: ____________________________________________

__________________________________________________________________________________

Are the child’s immunizations up to date?  ☐ Yes  ☐ No
## Family Medical History:

Check all that apply: □ Check if unknown □ Check if none apply

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