Date: _______________________________

Dear Parents/ Guardian,

We would like to take a moment to welcome your child as a new patient of Pediatric Neurology at the Herman and Walter Samuelson Children’s Hospital at Sinai. Your child is typically treated by the same physician, who knows the medical history and family background information. This continuity of care contributes to more positive health care outcomes. We value the critical role that parents play in keeping their children healthy. As a key member of our health care team, you have access to all members of your child’s team and participate in making all decisions about your child’s care. Your family will benefit from a very personal approach to care, similar to the experience of visiting a physician in a private practice.

Prior to your child’s visit, please fax or mail medical records including: x-rays, lab tests, growth charts, office notes pertaining to the visit, and documentation of any ED visits or hospitalizations in the past 3 months. Our fax number is 410-601-8227. Please ensure our office receives your child’s medical records at least 48 hours prior to the scheduled appointment. We ask that you arrive thirty minutes prior to or on time for the appointment or the appointment is subject to be rescheduled to complete the registration process. If you are unable to keep your child’s appointment kindly give 24 hours notice. We look forward to meeting you and your child.

______________________________ has an appointment with ________________________________ on ________________________ at_____________ am/pm at the _____________________________ location.

□ Sinai Hospital Michel Mirowski Medical Office Building (main office)
5051 Greenspring Avenue, Suite 202 Baltimore, Maryland 21209

□ Franklin Square Medical Center (Satellite office)
5009 Honeygo Center Drive, Suite 225 Perry Hall, Maryland 21128

□ Mt. Airy Health & Wellness Pavilion (Satellite office)
504 E. Ridgeville Blvd Mt. Airy, Maryland 21771

What to Bring with You:

<table>
<thead>
<tr>
<th>The completed registration packet</th>
<th>Referral from your pediatrician (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insurance cards</td>
<td>A list of medications and questions you may have for the physician.</td>
</tr>
<tr>
<td>Photo Identification</td>
<td>If your child is old enough, help him or her to add to the list too</td>
</tr>
<tr>
<td>Co-Payment</td>
<td>Books, games, snacks, formula, diapers, change of baby clothes or other necessities.</td>
</tr>
</tbody>
</table>
Patient Policies
We've found the following policies to be helpful in providing each of our patients with the best possible service. Your cooperation is appreciated.

Primary Care Referrals:
If your insurance carrier requires a referral from your primary care physician, please send your completed referral forms to us prior to your appointment. Patients cannot be seen without the appropriate referral.

Co-Payments:
Co-payments are due at the time of your scheduled appointment.

Methods of Payment:
We accept cash, checks, MasterCard, Visa and Discover. We do not accept American Express.

Delays:
Please call if you are running late. Patients arriving after their scheduled appointment time will be asked to reschedule. If our office is responsible for a delay, your session will be completed in its entirety.

No-Shows
Patients may be charged for missed appointments without a 24 hour cancellation notice. This charge is the patient's responsibility and cannot be billed to the insurance company. Missed appointment fees should be paid before scheduling subsequent appointments.

Cancellations:
If you are unable to keep an appointment, please contact the office at least 24 business hours prior to your scheduled appointment time. We request that patients who are unable to keep an appointment contact our office at least 24-business hours prior to the scheduled appointment time since there are usually other patients that could benefit from this appointment slot.

Forms Completion:
There is a $25 fee for completing forms for school, disability, camp etc.

If you have any questions regarding this information contact our office at 410-601-8300 or via email at pediatricneurology@lifebridgehealth.org. We look forward to meeting you and your child.
**Directions to Sinai Location**

Sinai Pediatric Neurology is now located in the Michel Mirowski Medical Office Building
5051 Greenspring Avenue
Suite 202 Baltimore, MD 21209

**From the North**
From Pennsylvania and northern Baltimore suburbs, take I-83 South. At junction with I-695 (Baltimore Beltway), enter I-695 heading West (Pikesville direction). Re-enter I-83 South at Exit 23. Proceed for approximately 3 miles and take Exit 10B, Northern Parkway.

**From the West**
From Howard County and points west, head east on I-70 or on I-795 to I-695 East (Baltimore Beltway, Towson direction). Take Exit 23 onto I-83 South (Jones Falls Expressway). Proceed for approximately 3 miles and take Exit 10B, Northern Parkway.

**From the East and Northeast**
From Towson, Harford County, and points farther north, take I-95 South to Exit 64, I-695 West (Baltimore Beltway, Towson direction). Take Exit 23 onto I-83 South (Jones Falls Expressway). Proceed for approximately 3 miles and take Exit 10B, Northern Parkway. Head west on Northern Parkway.

**From the South**
From the DC, MD, VA area, take I-95 North into downtown Baltimore via the I-395 Exit. Turn RIGHT at W. Pratt Street. Turn LEFT at S. President Street, which becomes I-83N/Jones Falls Expressway. Take I-83 North approximately 6 miles to Exit 10B, Northern Parkway West.

**DIRECTIONS FROM NORTHERN PARKWAY TO MIROWSKI BUILDING**
Proceed 0.6 miles up Northern Parkway and turn left at the stoplight onto Greenspring Avenue. Shortly after you pass under a footbridge across Greenspring Avenue, make the very first left into the driveway that leads up the hill to the parking lot. The driveway entrance is directly across from the Emergency Room (ER7) entrance and is marked by a blue sign pointing to the Mirowski Office Building and the Brain & Spine Institute.

**DIRECTIONS FROM THE HOFFBERGER BUILDING TO THE MIROWSKI BUILDING**
From the Belvedere Garage turn right onto West Belvedere Avenue, turn right onto Northern Parkway.

Please note the office is on the 2nd floor suite 202 of 5051 Greenspring Avenue. Please expect to pay for parking. Parking is located in front of the building.

**Directions to Franklin Square Location**

5009 Honeygo Center Drive, #225
Perry Hall, Maryland 21128
410-601-8300

From West:
Take I-695 east toward Towson/York PA. Merge onto MD-43/White Marsh Blvd via exit 31C on the left towards White Marsh. Turn left onto Honeygo Blvd. Turn right onto Honeygo Center Drive (Honeygo Center is 0.1 miles past E Joppa Road.)

From East
Take I-695 north Baltimore Beltway Outer loop. Merge onto I-95 via exit 33 towards New York. Merge onto MD-43 west White Marsh Blvd via exit 67B. Turn slight right onto Honeygo Blvd. Turn right onto Honeygo Center Drive. (Honeygo Center is 0.1 miles past E Joppa Road.)

Directions to Mt. Airy Location
Mt. Airy Health & Wellness Pavilion
504 E. Ridgeville Blvd.
Mt. Airy, MD 21771

From Frederick and points West: Take I-70 East to the Mt Airy exit (Exit 68). At the end of the exit ramp turn left on Ridge Rd.; at the traffic light make a right onto E. Ridgeville Rd. Follow E. Ridgeville Rd. around to the large parking lot where the Mt Airy Health and Wellness Pavilion is situated. Enter the building through the center main entrance and proceed to the lobby’s central registration area.

From Westminster and points North: Follow MD-27 south (approximately 17 miles from Westminster) to E. Ridgeville Rd. Take left onto E. Ridgeville Rd. Follow E. Ridgeville Rd. around to the large parking lot where the Mt. Airy Health and Wellness Pavilion is situated. Enter the building through the center main entrance and proceed to the lobby’s central registration area.

From points Southwest: Follow 270 North to I-70 East. Travel East on I-70 to the Mt. Airy exit (Exit 68). At the end of the exit ramp turn left on Ridge Rd. At the traffic light make a right onto E. Ridgeville Rd. Follow E. Ridgeville Rd. around to the large parking lot where the Mt. Airy Health and Wellness Pavilion is situated. Enter the building through the center main entrance and proceed to the lobby’s central registration area.

From Baltimore and points East: Take Baltimore Beltway (I-695) I-70 West to the Mt Airy exit (Exit 68). At the end of the exit ramp turn right onto Ridge Rd. At the traffic light make a right onto E. Ridgeville Rd. Follow E. Ridgeville Rd. around to the large parking lot where the Mt Airy Health and Wellness Pavilion is situated. Enter the building through center main entrance and proceed to the lobby’s central registration area.

IMPORTANT REMINDER CHECKLIST
PLEASE ARRIVE 30 MINUTES PRIOR TO YOUR APPOINTMENT TO COMPLETE THE REGISTRATION PROCESS

☐ Call the PCP’s office to have records sent

_Last office note, growth chart, labs or related test faxed to (410) 601-8227_

☐ Call us 48 hours prior to confirm records were received or at least 24 hours in advance if you need to cancel or reschedule

☐ Bring the COMPLETED New Patient Packet

☐ Bring your state/government issues photo id, patient’s insurance card(s), patient’s referral and/or co-pay, if required by insurance. It is the parents responsibility to obtain a referral to cover the appointment date.

_We accept Master Card, Visa, Discover, Cash & Checks_

☐ Call us if your phone #, address or insurance changes.

Please expect to pay for parking as there is a fee for parking on the main parking lot as well as in the garage.

_This applies to the Sinai location only_

☐ Did you respond to the Patient Portal invitation via email from Lifebridge Health?

_Parents of patients from birth to age 18 will only have proxy/ limited access to the child’s record_

**If medical records are not received prior to the appointment, the appointment is subject to being canceled or postponed.**
**Welcome to our office. In order to facilitate your child's evaluation, we'd appreciate you providing us with the following information:**

**Date of appointment:**

**Provider:**

- [ ] J. Alfre Caceres, M.D.
- [ ] Edward Gratz, M.D.
- [ ] Peggy Lazerow, M.D.

**Child's full name:** ________________________________  **Date of Birth:** __________________________

**Nickname:** ________________________________  **Male:** [ ]  **Female:** [ ]

**Name of your child's primary care physician/pediatrician:** ________________________________

**Physician's Address:** ________________________________  **Phone #** ________________________________  **Fax #** ________________________________

**Who referred you to our office (if different from physician above)?** ________________________________

**Name and phone number of your preferred pharmacy:** ________________________________

**Why are you coming to see us today?** ________________________________

**PAIN?** [ ] Yes  [ ] No

<table>
<thead>
<tr>
<th>PAIN LEVEL</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>NO HURT</td>
</tr>
<tr>
<td>1</td>
<td>HURTS LITTLE BIT</td>
</tr>
<tr>
<td>2</td>
<td>HURTS LITTLE MORE</td>
</tr>
<tr>
<td>3</td>
<td>HURTS EVEN MORE</td>
</tr>
<tr>
<td>4</td>
<td>HURTS WHOLE LOT</td>
</tr>
<tr>
<td>5</td>
<td>HURTS WORST</td>
</tr>
</tbody>
</table>

**Has your child had any medical tests performed due to this condition (X-rays, blood, urine, EEG tests, etc.)?**  
[ ] Yes  [ ] No

If yes, when/where? ________________________________

**Medical History**

**Medical problems or health concerns:**

1. ________________________________
2. ________________________________
3. ________________________________
4. ________________________________

**Prior hospitalizations (Reason/Date/Location):**

1. ________________________________
2. ________________________________

**Prior surgeries or outpatient procedures (Surgery name/Date/Location):**

1. ________________________________
2. ________________________________

**Please list any known medication, food, or other allergies:** ________________________________
DIVISION OF PEDIATRIC NEUROLOGY REGISTRATION FORM cont.

Birth History:
Any problems with pregnancy, labor, or delivery? ________________________________________________________________
Child's birth weight: _______________  Gestational age: ________ weeks
Any medical problems during first month of life? ________________________________________________________________

Social History:
Who lives at home with your child? ____________________________________________________________
Any pets at home? _______________________________________________________________________________________
Has your child traveled outside the U.S. in past 6 months? __________________________________________________
Home drinking water source: ___________________________________________________________________________
Current grade in school: ____________________________
How many school days were missed due to illness in the past year? _____________________________________________
For what illness(s)? ____________________________________________
Any unusual stresses at home or school? ____________________________________________________________

Has your child been diagnosed with any of the following? Please check all that apply.

| □ Asthma | □ ADHD/ ADD |
| □ Heart Murmur | □ Anxiety |
| □ Anemia | □ Depression |
| □ Diabetes | □ Other: __________________________________________ |

Review of Systems:
Please check the box below if your child has experienced any of the following in the past three months:

| General | □ Chills | □ Fatigue | □ Irritability | □ Weight loss or gain | □ Fever |
| Skin | □ Rashes | □ Jaundice | □ Other: |
| Eyes | □ Vision problems: | □ Other: |
| Ear, nose, throat | □ Hearing loss | □ Nasal discharge | □ Strep throat | □ Mouth sores | □ Oral thrush |
| □ Other |
| Chest | □ Wheezing | □ Chest pain | □ Coughing | □ Other |
| Hematology | □ Bleeding problems | □ Bruises easily | □ Other |
| Genitourinary | □ Bed wetting | □ Painful urination | □ Dark colored urine | □ Other |
| Musculoskeletal | □ Joint pain | □ Joint stiffness | □ Joint swelling | □ Fractures | □ Other |
DIVISION OF PEDIATRIC NEUROLOGY REGISTRATION FORM cont.

Name of MOTHER or female guardian ____________________________ Name of FATHER or male guardian ____________________________

Date of Birth: ____________________________ Date of Birth: ____________________________
S.S.No.: ____________________________ S.S.No.: ____________________________
Home Address: ____________________________ Home Address: ____________________________
Home Phone: ____________________________ Home Phone: ____________________________
Cell Phone: ____________________________ Cell Phone: ____________________________
E-Mail Address: ____________________________ E-Mail Address: ____________________________
Employer: ____________________________ Employer: ____________________________
Position Held: ____________________________ Position Held: ____________________________
☐ Full Time ☐ Part-time ☐ Full Time ☐ Part-time

BEST NUMBER TO CONTACT BEFORE 5:00PM
HOME ☐ CELL ☐ BUSINESS ☐
BEST NUMBER TO CONTACT AFTER 5:00PM
HOME ☐ CELL ☐ BUSINESS ☐

BEST NUMBER TO CONTACT BEFORE 5:00PM
HOME ☐ CELL ☐ BUSINESS ☐
BEST NUMBER TO CONTACT AFTER 5:00PM
HOME ☐ CELL ☐ BUSINESS ☐

Is your child covered under more than one insurance policy? ☐ Yes ☐ No

Person responsible for bill ☐ Mother ☐ Father ☐ Guardian/Other (Specify): ____________________________

Primary insurance co. name: ____________________________ Policy No. ____________________________
Insurance co. address ____________________________
Group Name ____________________________ Group No. ____________________________ Effective date ____________________________
DOCUMENTATION REQUEST

Sinai Hospital of Baltimore Faculty Practice Providers are dedicated to preserving your privacy and personal health information. **We are requesting Patient Medical Documentation for the doctor to review prior to their appointment** in order to provide the finest medical care possible. Thank you for your assistance.

Date: _______________  Appointment Date: __________________________

To: _______________________________________

Subscriber name ______________________________________ Relationship to patient ____________________

Secondary insurance co. name: __________________________ Policy No. __________________________

Insurance co. address __________________________________________________________________________

Group Name ___________________ Group No. ________________ Effective date ______

Subscriber name ______________________________________ Relationship to patient ________________

X ___________________________ X ____________________________
(Patient or Guardian/Date) (Office Official Witness/Date)
Patient Name: ________________________________
DOB: ___________________ Sex: ________________
Address: ____________________________________
____________________________________________
____________________________________________

The above named patient is presently being treated by one of our Pediatric Neurology physicians. In order to complete our evaluation of this patient, we need the following…

**Information Requested:**

XX Discharge Summary, Progress notes
XX Pathology Report, History and Physical, x-rays, EEG test results etc.
XX Consultation/Evaluations, Lab Reports
XX Genetic Testing Information, Psychological Testing
XX Outpatient Clinic Records, Records of any ED visits or hospitalizations in the past 3 months
XX Other *Anything that would assist in understanding why referred to the Pediatric Neurologist*

Please send the requested information to (MAIN OFFICE):

**Sinai Pediatric Neurology**
Michel Mirowski Medical Office Building
5051 Greenspring Avenue, Suite 202
Baltimore, MD 21209
Phone: 410-601-8300 Fax 410-601-8227

_______________________________________
Patient or Legal Guardian _________________________
_______________________________________
Witness
_______________________________________
Date

*If the records are not received prior to the appointment, the appointment is subject to being postponed until records are obtained*

**DIVISION OF PEDIATRIC NEUROLOGY PATIENT AUTHORIZATION FORM**

Sinai Hospital of Baltimore Faculty Practice Providers are dedicated to preserving your privacy and personal health information. Our employees are trained in the proper handling of your medical and financial records. We are requesting this Patient Authorization in order to continue to provide the finest medical care possible. Thank you for your assistance.

I authorize _____Sinai Pediatric Neurology_____ to:
(Dept/Division)

1. Call my home and/or work to remind me of upcoming appointments; in the event I am not there, leave a message on an answering machine.

2. Send reminder notices for upcoming appointments or when it is time to schedule an appointment.
3. Call my home or work and leave a message to contact the office. Make and/or receive calls from pharmacies on my behalf, including prescriptions. By FAX.

4. Update my personal demographic information either on the phone or in the office at the time of my appointment.

5. At my request, I give permission to discuss my personal health with the designated person(s) below:

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>______________________________</td>
<td>______________________________</td>
</tr>
<tr>
<td>Name</td>
<td>Relationship</td>
</tr>
<tr>
<td>______________________________</td>
<td>______________________________</td>
</tr>
<tr>
<td>Name</td>
<td>Relationship</td>
</tr>
</tbody>
</table>

I have read and agree to the above policies.

<table>
<thead>
<tr>
<th>Patient Name (print)</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>____________________</td>
<td></td>
</tr>
</tbody>
</table>

Signature of Patient/Guardian
SECURELY SEND A MESSAGE TO YOUR PROVIDER
REQUEST PRESCRIPTION REFILLS ONLINE
REQUEST AN APPOINTMENT ONLINE

My LifeBridge Health
Easily keep track of your medical information!

The My LifeBridge Health Patient Portal gives you free 24/7 access to the medical information you need, when you need it the most.

How does My LifeBridge Health work?
- Information entered into the My LifeBridge Health electronic medical record is automatically viewable through your My LifeBridge Health account.
- Access your portal online through any computer, smartphone or tablet.
- You can view or print your health care information.

What does My LifeBridge Health track?
Here’s a sample of the information included in the My LifeBridge Health portal:
- Lab results
- Immunizations
- Medications
- Procedures
- Discharge summaries
- Allergies
- Vital signs

Is the patient portal secure?
- My LifeBridge Health is only available through a secure website. You will be required to create a username and password and use them to sign in.
- LifeBridge Health has put rigorous safeguards in place to secure the health information in the My LifeBridge Health patient portal.

If you have any questions, please call 410-601-WELL (9355).