LIFEBRIDGE HEALTH
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) 601-8500 (press option 1).

- **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) 601-8500 (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

LIFEBRIDGE HEALTH
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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.
- ☐ **Complete any forms** that were included with your appointment reminder letter.
- ☐ 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) 601-8500 (press option 1).

Please bring the following items to your appointment:

- ☐ All forms included in this packet (please complete the forms before your appointment)
- ☐ 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 referring physician, primary care physician and anyone else whom you would like to receive your medical information.

Patient ID goes here

Patient Registration Form

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Please Print

Date: _____

Patient's Name: _____
Last First Middle Initial

Date of Birth (MM/DD/YYYY): _____ Sex (circle one): Male Female

Patient's Address: _____
Street

_____
City State Zip Code

E-mail: _____

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: _____

Patient ID goes here

Health Summary Form for New Patients

LIFEBRIDGE HEALTH.
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Date: _____

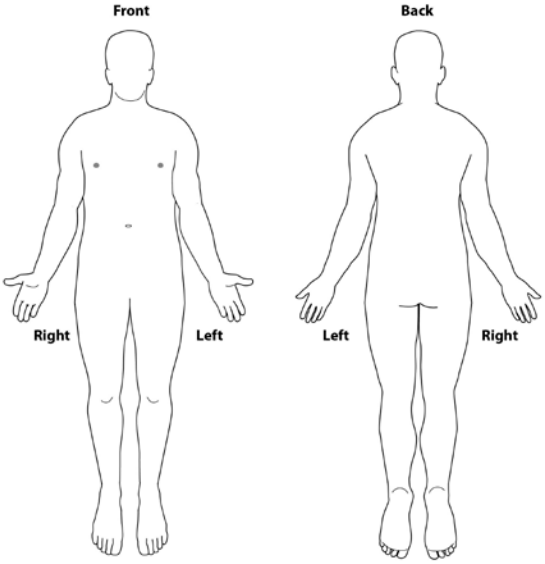
Name: _____
Last First Middle Initial

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

Sex: ☐ Male ☐ Female I am: ☐ Right handed ☐ Left handed ☐ Ambidextrous

Symptoms

Circle the part of the body that is bothering you.



Reason for your visit: _____

_____

_____

_____

Symptoms started because of: ☐ Fall/sports injury
☐ Fracture/break ☐ Twisting injury ☐ Spontaneously
☐ Motor vehicle accident – Date of accident: _____
☐ Work related injury – Date of injury: _____
☐ Other _____

Symptoms first began (date or year): _____

Symptoms got worse (date or year): _____

Symptoms include: ☐ Weakness ☐ Swelling ☐ Numbness/ tingling
☐ Instability (history of dislocation)

Talking Points for Your Visit Today

Please list the 2 or 3 most important questions that you have for the doctor today.

1. _____

2. _____

3. _____

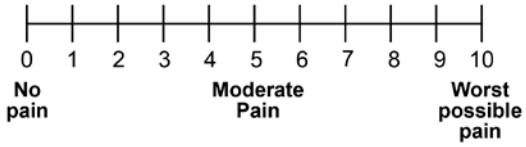
Describe the Pain

What makes the pain worse?_____

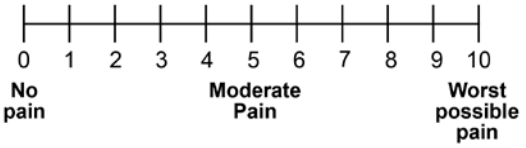
What makes the pain better?_____

Mark an "X" on the lines to show your level of pain.

Rate pain during activity



Rate pain at rest.



History of Treatment for This Problem

What other treatment have you tried for this problem (check all that apply)?

☐ Splinting ☐ Tens unit ☐ Injections
☐ Brace/orthotic ☐ Physical therapy ☐ Surgery

List muscle relaxants, anti-inflammatories, or pain medications that you have taken for this problem:

_____

Have you had any of the following tests performed for this problem? ☐ Yes (provide information below) ☐ No

Type of Test	Date of Test (approximate)	Location of Center that Performed Test
MRI		
Cat Scan		
X-ray		
Nerve Conduction Study		
Bone Scan		

Past Medical History

Check all that apply: ☐ I do not have any of the conditions listed below

☐ AIDS/HIV
☐ Alcoholism
☐ Alzheimer's disease
☐ Anemia
☐ Asthma
☐ Blood clots
☐ Cancer
☐ Chest pain
☐ COPD
☐ Depression
☐ Diabetes
☐ Drug abuse
☐ Gerd/Reflux
☐ Gout
☐ Heart attack
☐ Hepatitis
☐ High blood pressure
☐ Kidney disease
☐ Liver disease
☐ Osteoarthritis
☐ Osteoporosis
☐ Pacemaker
☐ Rheumatoid arthritis
☐ Seizures
☐ Sickle cell anemia
☐ Sleep apnea
☐ Stomach ulcers
☐ Stroke
☐ Thyroid
☐ Other _____
☐ Other _____
☐ Other _____

Surgical History

List all ORTHOPEDIC surgeries that you have had.

Date of Surgery	Type of ORTHOPEDIC Surgery	Reason for ORTHOPEDIC Surgery

Attach additional pages if necessary

List all OTHER SURGERIES AND SERIOUS ILLNESSES that required hospitalization.

Date of Surgery/Illness	Type of Surgery or Illness	Reason for Surgery or Hospitalization

Attach additional pages if necessary

Your Medications, Allergies, and Immunizations

Medications include:

- Vitamins
- Supplements
- Prescription medications
- Herbal supplements
- Over the counter medications

☐ **I am not currently taking any medications.**

Medication name	Dose (e.g., strength, number of pills)	Route (e.g., by mouth, inhaled, on skin)	How often do you take this medication?

Attach additional pages if necessary

Allergic to: ☐ Penicillin ☐ Latex ☐ Metal ☐ Aspirin ☐ Codeine ☐ Local Anesthetic ☐ Food _____

Other Medication Allergies/Adverse Reactions:_____

Other Allergies/Adverse Reactions:_____

Are your immunizations up to date? ☐ Yes ☐ No

Social History

Caffeine use? ☐ Yes ☐ No Number of caffeinated products per day:_____

Current alcohol consumption? ☐ Yes ☐ No Weekly amount:_____

Past alcohol consumption? ☐ Yes ☐ No Years of use:_____

Current tobacco use? ☐ Yes ☐ No Type:_____ Amount per week (packs, cans, etc.):_____

Past tobacco use? ☐ Yes ☐ No Type:_____ Number of years:_____

Current use of recreational/street drugs? ☐ Yes ☐ No Type:_____ Number of years:_____

Past use of recreational/street drugs? ☐ Yes ☐ No Type:_____ Number of years:_____

How many times a week do you exercise? _____

Family Medical History: Check all that apply to your father, mother, sister, brother, or grandparents.

☐ AIDS/HIV
☐ Alcoholism
☐ Alzheimer's disease
☐ Anemia
☐ Arthritis
☐ Asthma
☐ Cancer
☐ Depression
☐ Diabetes
☐ Drug abuse
☐ Gout
☐ Heart disease or heart attack
☐ High blood pressure
☐ Kidney disease
☐ Osteoporosis
☐ Stroke
☐ Thyroid
☐ Other _____

Review of Systems

Check all that apply: ☐ I do not have any of the conditions listed below

Constitutional
☐ Weight gain
☐ Weight loss
☐ Fever
☐ Weakness
☐ Malaise
☐ Insomnia
☐ Fatigue
☐ Chills
☐ Night sweats

Respiratory
☐ Shortness of breath
☐ Cough
☐ Breathing pain
☐ Wheezing
☐ TB exposure

Dermatology
☐ Contact allergy
☐ Rashes

Immunological
☐ Asthma
☐ Bee sting allergy
☐ Contact dermatitis to _____

Gastrointestinal
☐ Loss of appetite
☐ Nausea
☐ Vomiting blood
☐ Diarrhea
☐ Dark stool
☐ Abdominal pain
☐ Heartburn
☐ Jaundice
☐ Constipation

Metabolic
☐ Cold intolerant
☐ Heat intolerant

Head/Ears/Eyes/Nose/Throat
☐ Headaches
☐ Double vision
☐ Blurred vision
☐ Ringing in ears
☐ Vertigo (world spinning)
☐ Difficulty swallowing
☐ Hearing loss

Cardiovascular
☐ Chest pain
☐ Feel heart beating
☐ Fainting spells

Genitourinary
☐ Frequency
☐ Urgency
☐ Blood in urine
☐ Frequent night-time urination
☐ Incontinence

Neurological
☐ Seizures
☐ Tremors
☐ Numbness/tingling
☐ Dizziness/light-headed
☐ Incoordination
☐ Difficulty walking
☐ Memory loss
☐ Depression

Hematologic
☐ Easy bruising
☐ Easy bleeding

Reproductive
☐ Pain interfering with sex

Reviewed by (Provider Signature): _____ Date: _____