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.

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.

Dr. Apostolo's Orthopaedic History Form

Dear Valued Patient,
All of this material is private and fully protected.
Thank you for your understanding and patience!
-Dr. Apostolo

Contact Information

My Name: _____

My **CELLULAR** phone number is: (_____) _____-_____ ☐ Texting OK

My **WORK** phone number is: (_____) _____-_____ ext. _____

My **HOME** phone number is: (_____) _____-_____ My **E-MAIL** address is: _____

The **BEST** number to contact me is: ☐ CELL ☐ HOME ☐ WORK ☐ OTHER (_____) _____-_____

Address: _____ Apt #: _____ City: _____ State: ____ Zip: _____

Referral and Communication

Please fill in the information below

My Primary Care ☐ Doctor ☐ Physician Assistant ☐ Nurse Practioner is: _____

My last visit with my primary care provider (PCP) was on: _____/_____/_____

I authorize RIAO/Dr. Apostolo's Office to discuss/report/obtain my personal health information with those designated below.

☐ PCP _____As Above_____ Phone: (_____) _____-_____ Fax: (_____) _____-_____

☐ Referring Physician: _____ Phone: (_____) _____-_____ Fax: (_____) _____-_____

☐ Other Provider: _____ Phone: (_____) _____-_____ Fax: (_____) _____-_____

☐ Spouse/SO: _____ Cell: (_____) _____-_____ Work: (_____) _____-_____

☐ I authorize RIAO/Dr. Apostolo's Office to leave personal health information details on my voicemail and through my email.

☐ I authorize/request that Dr. Apostolo communicate to my lawyer/insurance regarding causation by a third party if applicable.

Background

Indicate your natural **hand dominance:** ☐ **Right** handed ☐ **Left** handed ☐ Ambidextrous

My **Age** is: _____ years and **I work (or last worked)** as a: _____

and I am now: ☐ Retired ☐ Disabled ☐ Semi-Retired ☐ Off Now but Working ☐ Working Currently

And my job is/was considered: ☐ Desk/Sitting ☐ Light Physical ☐ Medium Physical ☐ Hard Physical

I enjoy the following **Hobbies**: ☐ None ☐ Physical Sports/Exercise ☐ Walking/Staying Active ☐ Sedentary/Reading

My current **height**: _____ feet _____ inches, and my current **weight**: _____ pounds

Recent Fall Risk: I have fallen and/or consider myself at an increased risk of falling: ☐ Yes ☐ No

Testing & Treatment History

Please provide as much information as possible

I have had the following tests or treatments **related to my orthopaedic condition:** (Add details like where/what done)

☐ X-Ray: ☐ CT Scan: ☐ Electrical Test (EMG/NCB): ☐ Other:

☐ MRI: ☐ Blood Test: ☐ Bone Scan:

Allergies

☐ YES ☐ NO: I HAVE KNOWN ALLERGIES TO DRUGS OR SUBSTANCES

*Dr. Apostolo distinguishes a **true allergy** like a med that caused breathing problems or required a doctor's care from a **sensitivity** like stomach upset, rash, or feeling lightheaded. Be specific and feel free to list all meds, foods, latex, etc.*

Offending Substance:	Breathing Problems:	Sensitivity:	Describe what happened:	Last Exposure:
_____	☐ Yes	☐ Yes	_____	_____
_____	☐ Yes	☐ Yes	_____	_____
_____	☐ Yes	☐ Yes	_____	_____

Medication Review:

☐ **I take no prescribed medications** ☐ **I take prescribed medications regularly**

My preferred pharmacy is: _____

Located at: _____ Phone: _____

The names of my current medications are: _____

_____

Over-the-Counter Meds, Supplements and Ancillary Care ☐ NONE

Please check all that you have used regularly or for this problem

☐ Tylenol	☐ Aspirin	☐ Benadryl	☐ Splinting	☐ Injections: _____
☐ Advil/Ibuprofen	☐ Cough Medicine	☐ St. John's Wort	☐ Brace/Orthotic	☐ Chiropractic/Acupuncture
☐ Aleve/Naproxen	☐ Expectorant	☐ Vitamins	☐ TENS Unit	☐ Surgery
☐ Steroid Creams	☐ Decongestants	☐ Herbal Supplements	☐ Physical Therapy	☐ Other: _____
☐ Glucosamine	☐ Chondroitin	☐ Steroid Dose Pack	☐ Shock or Laser Treatment	_____

Alcohol Use

The best description of my lifelong alcohol use is:

☐ I never drank heavily **or** at all
☐ I drank heavily in the past but no longer
☐ I am a recovered alcoholic
☐ I drink beer/wine/liquor occasionally/holidays/weekends/parties
☐ I drink #_____ beer/wine/liquor daily

Tobacco Use/Exposure

The best description of my lifelong tobacco exposure is:

☐ I never smoked
☐ I quit smoking _____ packs/day Year:_____
☐ I smoke occasionally/socially less than a pack per week
☐ I smoke _____ packs/day **or** _____ packs/week

Recreational Drug Use

The best description of my lifelong use is:

☐ I never used any recreational drugs or misused prescription drugs
☐ I have misused prescription drugs: _____
☐ I have used recreational drugs: _____
☐ I quit using _____ since _____
☐ I use _____ occasionally/regularly
☐ I use _____ daily

Additional Notes:

Procedure Review:

I have had the following surgeries/procedures in my life: ☐ **None**

_____

_____

_____

_____

To create this list, it may be helpful to begin with your first operation and list chronologically, or to list by body parts such as head, chest, abdomen, legs, and arms. Don't forget operations linked to major diagnoses such as arthritis, cancer or vascular disease.

Family History *Please check all problems your parents, grandparents or siblings have or had:*

- ☐ Alcohol/Drug Abuse
- ☐ Anemia
- ☐ Anesthesia Problems
- ☐ Asthma
- ☐ Arthritis- Rheumatoid
- ☐ Arthritis-Osteoarthritis
- ☐ Blood Clots
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Gout
- ☐ Heart Attack/Heart Disease
- ☐ High Cholesterol/Lipids
- ☐ High Blood Pressure/HTN
- ☐ Mental Illness
- ☐ Obesity
- ☐ Osteoporosis/Multiple Fractures
- ☐ Stroke Under Age 50
- ☐ Other:_____
- ☐ **None/Don't Know**

Symptom Review:

Check recent/current symptoms: ☐ None ☐ Any Other:_____

- ☐ Weight Gain/Loss
- ☐ Fever/Chills
- ☐ Fatigue or malaise
- ☐ Night Sweats
- ☐ Feel Down
- ☐ Mood Changes
- ☐ Anger
- ☐ Chest Pain
- ☐ Heart Racing
- ☐ Cold Feet
- ☐ Irregular Heart Beat
- ☐ Pain w/Deep Breath
- ☐ Productive Cough
- ☐ Short of Breath
- ☐ Wheezing
- ☐ Tremor or Shaking
- ☐ Unsteadiness/Fall
- ☐ Rash
- ☐ Breast Lump
- ☐ Scaly Skin/Scalp
- ☐ Nail Deformity
- ☐ Heartburn
- ☐ Blood in Stool
- ☐ Constipation
- ☐ Pain w/ Urination
- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Losing Hair
- ☐ Drink a Lot of Fluids
- ☐ Muscle Cramps
- ☐ General Weakness
- ☐ Loss of Motion
- ☐ Morning Stiffness
- ☐ Feel Cold Always
- ☐ Change in Appetite
- ☐ Hearing Loss
- ☐ Hoarseness
- ☐ Pain/Loose Teeth
- ☐ Glasses/Contacts
- ☐ Watery/Itching Eyes
- ☐ Easy Bleeding
- ☐ Swollen Glands
- ☐ Varicose Veins
- ☐ Multiple Joint Swelling
- ☐ Frequent Infections

Diagnosis Review:

Check any diagnosis ever made by a physician, *even if treated*: ☐ None ☐ Other: _____

- ☐ Obesity
- ☐ HIV/AIDS
- ☐ Anesthesia Problems
- ☐ Cancer:_____
- ☐ Depression/Anxiety
- ☐ Insomnia
- ☐ Alzheimer's Dis.
- ☐ Alcohol/Drug Abuse
- ☐ Coronary Artery Disease
- ☐ Hypertension
- ☐ Peripheral Vascular Disease
- ☐ Lymphedema
- ☐ Varicose Veins
- ☐ COPD
- ☐ Asthma
- ☐ Panic Attacks
- ☐ Pulmonary Hypertension
- ☐ Neuropathy
- ☐ History of Stroke/TIA's
- ☐ Seizures
- ☐ Neurologic Disease
- ☐ Breast Cancer
- ☐ Psoriasis/Eczema
- ☐ Melanoma
- ☐ GERD/Reflux
- ☐ IBS/Irritable Bowels
- ☐ Constipation
- ☐ Jaundice/Liver Disease
- ☐ Hepatitis
- ☐ UTI/Infections
- ☐ Renal Failure
- ☐ Polycystic Ovary
- ☐ Hysterectomy
- ☐ Diabetes
- ☐ Thyroid Disorder
- ☐ High Cholesterol/Lipids
- ☐ Post-menopausal
- ☐ Arthritis-Osteo
- ☐ Arthritis-Rheumatoid
- ☐ Gout
- ☐ Osteoporosis
- ☐ Migraines
- ☐ Sleep Apnea
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Anemia
- ☐ Blood Clots
- ☐ Sickle Cell
- ☐ Environmental Allergies
- ☐ Fibromyalgia

☐ Past medical history/family history/social history/review of systems all reviewed _____ / _____
PMA **KMS**

Pain: *Please circle the number on **each** scale that best corresponds to the respective question*

My pain severity **now** is:
No Pain — The Worst
0 1 2 3 4 5 6 7 8 9 10

My **average daily** pain is:
No Pain — The Worst
0 1 2 3 4 5 6 7 8 9 10

My pain at its **worst** is:
No Pain — The Worst
0 1 2 3 4 5 6 7 8 9 10

My pain on a **good day** is:
No Pain — The Worst
0 1 2 3 4 5 6 7 8 9 10

The following makes my pain **worse**: *(Check all that apply)*

- ☐ Sleeping
- ☐ Hand Activities
- ☐ Overhead Use
- ☐ Walking
- ☐ Exercise
- ☐ Work
- ☐ Worse in Morning
- ☐ Stress
- ☐ Therapy
- ☐ Other: _____

The following makes my pain **better**: *(Check all that apply)*

- ☐ Pills
- ☐ Exercise
- ☐ Rest
- ☐ Chiropractic
- ☐ Wrap
- ☐ Splint
- ☐ Cold
- ☐ Heat
- ☐ Injection
- ☐ Narcotics
- ☐ Therapy
- ☐ Brace/Orthotic
- ☐ TENS Unit
- ☐ Surgery:_____
- ☐ Other: _____

Dr. Apostolo's Orthopaedic History Form

Please list the problems you would like to discuss during your appointment:

1) _____

2) _____

3) _____

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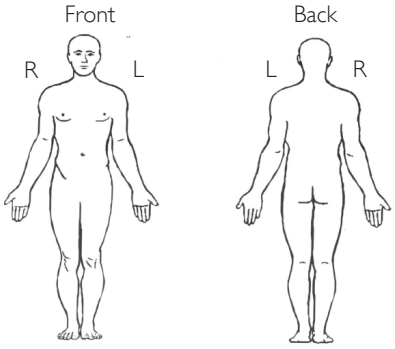
STICKER

by BPA Productions ™

February 28, 2016 10:05 PM

Please circle hurt body parts:



Provide more details about your symptoms below:

My problems **started:**
(___) years ago, (___) months ago,
(___) weeks ago, (___) days ago.

But my problems have gotten **worse** in the past
(___) months, (___) weeks,
(___) days, or ☐ hasn't changed.

Other details:

_____

Check Any/Explain:

- ☐ Numbness
- ☐ Tingling
- ☐ Sharp Pain
- ☐ Dull, Aching
- ☐ Result of Fall
- ☐ Sports/Injury
- ☐ Gradual Onset
- ☐ Sudden Onset
- ☐ Night Pain
- ☐ Swelling
- ☐ Clicking
- ☐ Joint Locking
- ☐ Neck Pain
- ☐ Back Pain
- ☐ Shooting Pain
- ☐ Other: _____

Provide any additional details: _____

Detail any recent related changes or testing: _____

Privacy Notice (HIPAA)

Lifebridge Health (LBH) Notice of Privacy Practices provides information regarding how we may use and disclose your protected health information (PHI). Dr. Apostolo encourages you to read this policy and request additional information or clarification from any staff member. By signing this form, you acknowledge receipt of the ***Lifebridge Health Notice of Privacy Practices***.

Narcotic Policy

Dr. Apostolo does not manage chronic pain or narcotic use but will prescribe medications for acute pain and perioperative pain. Patients with inappropriate narcotic requests, chronic pain without an expected timetable for improvement, high dose requirements, or narcotic requests outside the scope of an acute setting will be referred for appropriate specialty management. Submission of this form indicates your acceptance of Dr. Apostolo's Narcotic Policy.

Please Sign Here: X_____ Patient Verification

Reviewed: _____ /_____
PMA / KMS

Office Use Only:

X-Ray Order/Review		Forearm	R L	Hip 1V	R L
		Wrist	R L	Hip 2V	R L
Chest 1V		Hand	R L	Femur	R L
Chest 2V		R Fing. 1 2 3 4 5		Knee Bilat	
Chest 3V		L Fing. 1 2 3 4 5		Knee 30 60 90	
Ribs Uni		Basal Jt.		Knee 1V or 2V	R L
CSpine 2V		T/L Junction		Knee 3V	R L
CSpine Comp.		T-Spine		Knee 4V	R L
Sternum		L-Spine 2V		Tib/Fib	R L
Clavicle	R L	L-Spine 4 V		Ankle	R L
AC Joint	R L	L-Spine F/E		Foot	R L
Shoulder	R L	S.I. Joint	R L	Heel	R L
Scapula	R L	Pelvis		R Toes 1 2 3 4 5	
Humerus	R L	Pelvis 3V		L Toes 1 2 3 4 5	
Elbow	R L	Hip Bilat 3V			

Office Procedure

Injection	Kenalog
Aspiration	Xylocaine
Procedure	Epinephrine

I received, understand, and accept the information including alternative treatments and the potential risks and benefits. My questions have been answered and I consent to having the recommended in-office treatment.

X _____

☐ Time Out @ _____
☐ Self Certification/ID
☐ Verified Proc./Site/Side

by P.M. Apostolo _____
by K.M. Scott _____