

# 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](http://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



Rubin Institute for  
Advanced Orthopedics

**CARE BRAVELY**

## **International Center for Limb Lengthening**

Sinai Hospital of Baltimore, 2401 West Belvedere Avenue, Baltimore, MD 21215  
Phone: 410-601-BONE (2663) • Toll free: 844-LBH-RIAO • Website: [www.LimbLength.org](http://www.LimbLength.org)

© May 2019 Rubin Institute for Advanced Orthopedics, Sinai Hospital of Baltimore

# 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.



Rubin Institute for  
Advanced Orthopedics

**CARE BRAVELY**

## International Center for Limb Lengthening

Sinai Hospital of Baltimore, 2401 West Belvedere Avenue, Baltimore, MD 21215  
Phone: 410-601-BONE (2663) • Toll free: 844-LBH-RIAO • Website: [www.LimbLength.org](http://www.LimbLength.org)

© May 2019 Rubin Institute for Advanced Orthopedics, Sinai Hospital of Baltimore

# Patient Registration Form

Patient ID Goes Here

## 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: \_\_\_\_\_



Rubin Institute for  
Advanced Orthopedics

**CARE BRAVELY**

## International Center for Limb Lengthening

Sinai Hospital of Baltimore, 2401 West Belvedere Avenue, Baltimore, MD 21215  
Phone: 410-601-BONE (2663) • Toll free: 844-LBH-RIAO • Website: [www.LimbLength.org](http://www.LimbLength.org)  
© May 2019 Rubin Institute for Advanced Orthopedics, Sinai Hospital of Baltimore

# Health Summary Form for Pediatric Patients

Patient ID Goes Here

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: \_\_\_\_\_

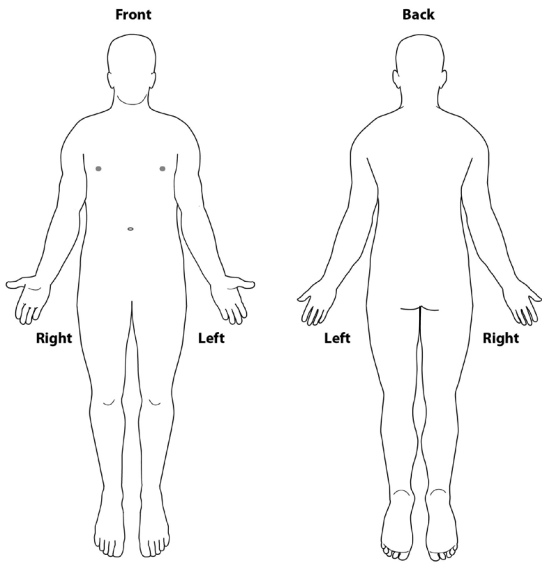
Mother's Occupation: \_\_\_\_\_ Father's Occupation: \_\_\_\_\_

The child lives with:  Family  Guardian  Care facility  Group home

## SYMPTOMS:

Reason for your visit: \_\_\_\_\_

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



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: \_\_\_\_\_

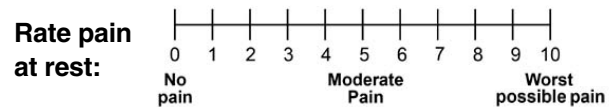
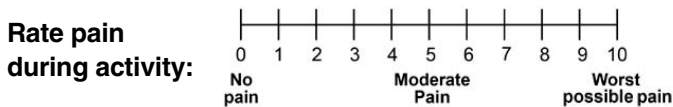
Physical therapy \_\_\_\_\_ times per week for \_\_\_\_\_ months

## 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.



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.**

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

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/Anxiety

**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
- Prescription medications
- Over the counter medication
- Vitamins
- Herbal supplements

My child is not currently taking any medications.

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

Attach additional pages if necessary

**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

	Father	Mother	Brother	Sister	Paternal Grandfather	Paternal Grandmother	Maternal Grandfather	Maternal Grandmother
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: _____								
Other: _____								