WELCOME- OUR PHILOSOPHY

Dear Patient,

Thank you for choosing me to provide your orthopedic care. My team and I will make every effort to treat you with courtesy, respect and kindness, while providing the highest level of care possible.

I truly understand the frustration of having to complete new forms each time you see another physician; however, in order to help me treat you accurately and efficiently, I would appreciate it if you would take a few minutes to complete the attached forms as accurately and completely as possible. Please be sure to fill out a separate history sheet for each area of the body for which you have been scheduled for your appointment.

I have found that two of the factors that create the greatest delay during office hours are the necessity for me or my physician assistant to personally complete these forms with or for the patient, and the insistence by patients that they be seen for a problem for which they are not scheduled “as long as they are here”. As a result the waiting time for other patients is increased as is the level of frustration for all of us. Your cooperation will enhance your experience with my practice.

My staff and I spend a great deal of the time during the first visit educating our patients about their diagnosis and together determining a customized treatment plan that will best suit their needs. We feel that when our patients understand their own bodies and the numerous treatment options, they have more control of their problem and can be proactive in their treatment. I have found that if patients write down their questions it helps insure that they don’t forget to ask for information that is important to them.

As a result of this philosophy, and the occasional need to fit in patients with emergency conditions, we will at times find it hard to stay on schedule. Please know that we do respect your time, and we will make every effort to see you as close to your scheduled time as possible.

We understand that schedules change and that there may be a need to cancel or reschedule your appointment. Please give us at least 24 hours notice so that we can offer your appointment time to another patient.

I look forward to getting to know you and helping you with your orthopedic problem.

Sincerely,

Ben Rubin, M.D.
YOUR FIRST VISIT

1. Please read the patient welcome letter on our website which explains our philosophy of care.

2. Please complete the forms on our website:
   - OSI Patient Registration Form
   - Orthopedic Questionnaire
   - General Health History

3. Insurance information
   Please bring your insurance card and a photo ID

4. Imaging studies
   Please bring any recent x-rays, MRI or CT scans related to your injury.
   Please bring a CD of the studies or the actual films, not just the reports

5. Clothing
   Female shoulder patients - please bring or wear a tank top, halter or sports bra

   Hip, knee and ankle patients – please bring or wear a pair of shorts

   Neck and back patients – will be provided with examination gowns
# Patient Registration

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<th><strong>Primary Care Physician</strong></th>
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<th><strong>Phone number</strong></th>
<th><strong>Home</strong></th>
<th><strong>Cell</strong></th>
<th><strong>Work</strong></th>
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<th><strong>Driver’s License #</strong></th>
<th><strong>Employer</strong></th>
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<th><strong>Relationship</strong></th>
<th><strong>Phone</strong></th>
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<tr>
<th><strong>Date of injury/onset of symptoms</strong></th>
<th><strong>Was this an injury?</strong></th>
<th><strong>If yes, Where did your injury occur?</strong></th>
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<td>WORK AUTO HOME SCHOOL OTHER:</td>
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<th><strong>Phone</strong></th>
<th><strong>Guarantor Responsible Party</strong></th>
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<th><strong>Social Security Number</strong></th>
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I hereby assign the insurance benefits to which I am entitled, directly to ORTHOPAEDIC SPECIALTY INSTITUTE, a medical group. I understand that I am financially responsible for all charges regardless of insurance verification, benefits and eligibility. I authorize release of medical records and information regarding medical history that is requested by the insurance company. A photocopy of this authorization is accepted with the same authority as original.

Photo identification and insurance cards must be presented at the time of service to enable OSI to submit claims to your insurance carrier. Should identification and insurance cards not be presented, you will become a cash patient with payment in full due at the time of service.

This agreement will remain valid from this day forward to include all future services relating to the above patient.

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**SIGNATURE OF PATIENT/GUARDIAN**

**DATE**
SPORTS MEDICINE HEALTH QUESTIONNAIRE

Please answer each question as completely as possible.
This information will help diagnose and treat your condition.

Patient Name: ____________________________

DOB: ________ Age: ____ Sex: □ Male □ Female

Occupation: ________________________________

Who referred you to see me today? ________________

Today's Date: ______________

Height: ____________________

Weight: ____________________

Dominant Hand: □ right □ left

Body part to be examined:
□ Right □ Left
□ Shoulder □ Knee □ Elbow □ Hip □ Other ________________________

How and when did the injury occur or the symptoms begin?

At the onset of this problem did you notice any of the following?
□ A “pop” □ Tearing sensation □ Immediate swelling

Has anyone previously treated you for this condition? ________________________

If so, when? ______________

Previous Treatment: Check all that apply and indicate your response to treatment.

□ NONE

□ X-rays Results:

□ MRI Results:

□ CT scan Results:

□ EMG Results: □ Physical therapy __________________

□ Chiropractor Results: □ Acupuncture

□ Cortisone Injection How many in the last 12 months? ________ Any relief? ________

□ Viscosupplementation (Orthovisc, Euflexxa, Synvisc) Last injection? ________ Any relief? ________

□ Medication: □ Anti inflammatories ________ □ Pain medications ________ □ Other ________

□ Brace □ Orthotics/Insoles

□ Other: __________________________________________________________________________
Current Symptoms: Please check all that apply.

Do you currently have any of the following complaints?

- Catching/popping/locking
- Grinding
- Swelling
- Weakness
- Instability
- Numbness / tingling
- Loss of motion

Which of the following describes your pain?

- Sharp/Stabbing
- Aching
- Burning
- Throbbing
- Constant
- Intermittent
- Awakens me from sleep _____ nights per week
- During activities
- After activities

Where is your pain located?

- Front
- Back
- Inside
- Outside
- Top

What activities aggravate your condition?

What makes your condition feel better?

Have you had any prior injuries to this area of your body? (If yes, please describe the injury and its prior treatment)

Surgical History: Check any surgeries that you have had. Please indicate the year of surgery to the best of your knowledge.

- NONE
- Appendectomy
- Gall Bladder
- Vascular Bypass...
- Heart Surgery
- Hysterectomy
- Tonsillectomy
- Arthroscopic Surgery: Shoulder
- Knee
- Hip
- Other
- Total Joint Replacement: Knee
- Hip
- Shoulder
- Back Surgery: specify:
- Fracture Repair: specify:
- Other:

If you have had any problems with anesthesia, explain:
Patient Name: __________________________

**Past Medical History:** Have you ever had any of the following? Check all that apply and specify as indicated.

**General:**
- □ Cancer
- □ Sleep apnea

**Head-Ears-Eyes-Nose-Throat:**
- □ High blood pressure
- □ Coronary artery disease
- □ Coronary stent/angioplasty
- □ Heart attack
- □ Mitral valve prolapse

**Cardiac:**
- □ Bladder infections
- □ Venereal disease
- □ Kidney disease

**Gastrointestinal:**
- □ Ulcer disease
- □ GERD
- □ Gallstones
- □ Diverticulitis

**Endocrine:**
- □ Diabetes
- □ Hypothyroid
- □ Hyperthyroid

**Musculoskeletal:**
- □ Osteoarthritis
- □ Rheumatoid arthritis
- □ Osteoporosis
- □ Fibromyalgia
- □ Ankylosing spondylitis
- □ Scoliosis

**Hematologic:**
- □ Bleeding disorder
- □ History of DVT/PE
- □ Blood clots

**Infectious Disease:**
- □ HIV
- □ Hepatitis A
- □ Hepatitis B
- □ Hepatitis C

**Neurological:**
- □ Seizures
- □ Balance problems
- □ Headaches
- □ Migraines
- □ Peripheral neuropathy
- □ History of stroke
- □ Multiple sclerosis

**Psychiatric:**
- □ Depression
- □ Bipolar
- □ Anxiety
- □ Manic
- □ History of drug dependency
- □ History of alcohol dependency

**Skin:**
- □ Eczema
- □ MRSA/Staph infection

Date Treated: ____________

**Medications:** Use the back of this page if additional space is needed. Remember antibiotics, blood thinners, insulin, and heart medications.

- □ NONE

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<th>Strength</th>
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**Allergies or Drug Reactions:** Check all that apply.

- □ NO KNOWN DRUG ALLERGIES
- □ Penicillin
- □ Adhesive Tape
- □ Codeine
- □ Sulfas
- □ Latex
- □ Morphine
- □ Aspirin
- □ Iodine
- □ Demerol
- □ NSAID’s
- □ Other: ________________

**Social History:** Please mark every area.

**Tobacco use:**
- □ Yes
- □ No
- □ Former

**Cigarettes:**
- □ Pack(s) per day:
- □ How many years:
- □ If you quit, when?

**Other tobacco use:**
- □ Amount per day:
- □ How many years:
- □ If you quit, when?

**Alcohol use:**
- □ Yes
- □ No

**Are you currently able to work?**
- □ Yes
- □ No

**Sports and Recreational Activities:** ________________
Review of Systems: Check any illnesses you currently have.

General:
- ☐ Fevers
- ☐ Weight loss or gain
- ☐ Difficulty sleeping
- ☐ Night sweats

Genitourinary:
- ☐ Urinary frequency
- ☐ Urinary retention
- ☐ Urinary incontinence

Neurological:
- ☐ Numbness or weakness
- ☐ Difficulty walking

Pulmonary:
- ☐ Shortness of breath
- ☐ Cough

Gastrointestinal:
- ☐ Nausea
- ☐ Vomiting

Head-Ears-Eyes-Nose-Throat:
- ☐ Difficulty swallowing
- ☐ Difficulty breathing
- ☐ Vision loss or change
- ☐ Hearing loss or change
- ☐ Tinnitus (ringing in ears)

Cardiac:
- ☐ Chest pain

Family History: Has anyone in your family had any of the following problems?

☐ No significant past family history
☐ Unknown family history

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<tr>
<th>Disease</th>
<th>Mother</th>
<th>Father</th>
<th>Brothers</th>
<th>Sisters</th>
<th>Daughters</th>
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<td>Stroke</td>
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<td>Cancer (type)</td>
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<td>Arthritis</td>
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<td>Other (please specify)</td>
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Primary Care Physician: ____________________________________________________________

Telephone #: ___________________________ City: ________________________________

Would you like a letter sent to your doctor?  ☐ yes  ☐ no

Cardiologist: _________________________________________________________________

Telephone #: ___________________________ City: ________________________________

*Please provide your pharmacy information. This will allow us to send medications to your pharmacy.*

Pharmacy: _________________________________________________________________

Address: _________________________________________________________________

City: ___________________________ Telephone #: ___________________________