The Herman & Walter Samuelson
CHILDREN'S
HOSPITAL AT SINAI
A LIFEBRIDGE HEALTH CENTER

**Division of Pediatric**
**Gastroenterology and Nutrition**
**Morton Mower Medical Office Building**
**2411 West Belvedere Avenue, Suite 407**
**Baltimore, Maryland 21215-5271**
**Tel 410 601 8663 Fax 410 601 5389**

**GIA BRADLEY, MD. Chief**
**SANA MANSOOR, MD**
**BRYNN O'LAUGHLIN, MD**
**CHRISTINA L. SHUJA, CRNP**
**STEPHANIA CADET-DARBY, MSN, RN**

**Dear Parents/Guardians,**

We would like to take a moment to welcome your child as a new patient of Pediatric Gastroenterology and Nutrition at the Herman and Walter Samuelson Children's Hospital at Sinai. The Division of Pediatric Gastroenterology and Nutrition treats children from infancy to young adulthood for disorders of the digestive system. A comprehensive, multidisciplinary team, including a pediatric gastroenterology provider, gastroenterology nurse and pediatric dietitian, works closely with patients and their families to treat these disorders. The division provides state-of-the-art treatments, including the latest biological therapies for inflammatory bowel disease. Your family will benefit from a personal approach to care, similar to the experience of visiting a physician in a private practice.

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.

The enclosed welcome packet includes information we would like you to complete prior to your child's visit to expedite your registration process. The packet also includes a request for pertinent medical information pertaining to your child's visit. We ask that you or the referring physician's office fax this information to our office prior to your child's appointment for the provider to review and obtain additional information if necessary. If you have any questions, feel free to contact our office at 410-601-8663.  We look forward to your visit.

Sincerely,

Pediatric Gastroenterology and Nutrition

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Date: ____________

Dear Parent Guardian:

__________________ has an appointment with _____________________

on __________________ at_______________ at the _________________________ location.

☐ Sinai Hospital, Morton Mower Medical Office Building
2411 West Belvedere Avenue, Suite 407, Baltimore, Maryland 21215-5271

We are not located within the Children's Hospital. The Morton Mower Medical Office Building is the red brick building across from the main parking lot. **Expect to pay for parking.** You can park in our main visitor's parking lot or in the Belvedere Garage. To access the garage, continue on Belvedere Avenue past the main entrance and the Belvedere garage will be on your left.

☐ Lifebridge Health Pavilion @ Quarry Lake
2700 Quarry Lake Drive, Suite 270, Baltimore, MD 21209

Parking is located directly outside of the building and there is no fee.

☐ Lifebridge Health Pediatrics
8000 Loch Raven Blvd, Towson, MD 21286

We are located in the same building as Express Care. Parking is located directly outside of the building and there is no fee.

Please bring the completed forms with you to your child's appointment. Prior to the visit, you can mail/email/fax medical records, including X-rays, lab tests, growth charts, office notes pertaining to the visit, and documentation of any ED visits or hospitalizations within the past 3 months. Our email address is pediatrics_gastroenterology@lifebridgehealth.org (*this email address is ONLY for receiving documents), and our fax number is 410-601-5389.

Updated 9/2024

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**Please ensure our office receives your child's medical records at least 48 hours prior to the scheduled appointment or your appointment will be subject to cancellation. We ask that you arrive at least 15 minutes prior to your appointment to complete the registration process.**

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## What to Bring with You:

| The completed registration packet | Insurance referral from your pediatrician (if applicable) |
|---|---|
| Insurance cards | A list of medications |
| Photo Identification | Questions you may have for the provider |
| Co-Payment | |

### Accompanying minors

All patients under the age of 18 must be accompanied by an adult for all visits. If a primary guardian cannot be present, then the accompanying individual needs to be 18+ years of age with photo identification and should bring written permission from the primary guardian.

### Delays

Please call if you are running late. Patients arriving more than 10 minutes late may 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.

**DIVISION OF PEDIATRIC GASTROENTEROLOGY AND NUTRITION**
LifeBridge Health Pediatrics

## Background Information

*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:** Gia Bradley, MD Sana Mansoor, MD Brynn O'Laughlin, MD Christina Shuja, CRNP

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

Preferred name: _________________________________ Preferred pronouns: _____________________________________

**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?** _______________________________________________________________________

____________________________________________________________________________________________________________

Has your child had any medical tests performed due to this condition (X-rays, blood, urine, stool 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. ______________________________________________________________________________________________

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2. ______________________________________________________________

Please list any known ALLERGIES (medication, food, or other): ______________________________________________

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LifeBridge Health Pediatrics

**Current Medications:**

| Medication name | Dose | Frequency (How often it is given) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Birth History:**

Any problems with pregnancy, labor, or delivery? ___________________________________________

Child's birth weight: ________________ Gestational age: ________ weeks

In the first week of life, was the baby jaundiced? Yes No

In the first week of life, were bowel movements normal? Yes No

Were bowel movements normal during first month of life? Yes No

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? ___________________________________________

Current grade in school: ______________________

How many school days were missed due to illness in the past year? ___________________________________________

For what illness (es)? ___________________________________________

Any unusual stresses at home or school? ___________________________________________

**Diet History:**

Was your child breast-fed? __________ If so, for how long? __________

Was your child formula-fed? _________ If so, what infant formulas were used? ______________________________

What is your child's current preferred drink? ___________________________________________

Foods your child is not allowed to eat at this time: ___________________________________________

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**Family History:**

Please place a check mark in the appropriate box if any of the listed family members have a condition listed below:

| Condition | Mother | Father | Brother | Sister | Maternal grandmother | Maternal grandfather | Paternal grandmother | Paternal grandfather |
|---|---|---|---|---|---|---|---|---|
| Autoimmune disease (ex. Lupus) | | | | | | | | |
| Celiac disease | | | | | | | | |
| Colon cancer | | | | | | | | |
| Constipation | | | | | | | | |
| Crohn's Disease | | | | | | | | |
| Cystic fibrosis | | | | | | | | |
| Food allergies | | | | | | | | |
| Gallstones | | | | | | | | |
| Gastroesophageal reflux | | | | | | | | |
| Genetic diseases | | | | | | | | |
| Hepatitis | | | | | | | | |
| Hiatal hernia | | | | | | | | |
| Intestinal Polyps | | | | | | | | |
| Irritable bowel syndrome | | | | | | | | |
| Liver problems | | | | | | | | |
| Migraine headaches | | | | | | | | |
| Pancreatitis | | | | | | | | |
| Peptic ulcer disease | | | | | | | | |
| Thyroid disease | | | | | | | | |
| Ulcerative colitis | | | | | | | | |

Are there any other medical conditions that run in the family that are not mentioned above?

______________________________________________________________________________

______________________________________________________________________________

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**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** | ☐ Anemia | ☐ Bleeding problems | ☐ Bruises easily | ☐ Other | |
| **Genitourinary** | ☐ Bed wetting | ☐ Painful urination | ☐ Dark colored urine | ☐ Other | |
| **Musculoskeletal** | ☐ Joint pain | ☐ Joint stiffness | ☐ Joint swelling | ☐ Fractures | ☐ Other |
| **Neurological** | ☐ Headache | ☐ Loss of consciousness | ☐ Seizures | ☐ Dizziness | ☐ Other |

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

| | |
|---|---|
| ☐ Asthma | ☐ ADHD/ ADD |
| ☐ Heart Murmur | ☐ Anxiety |
| ☐ Diabetes | ☐ Depression |
| ☐ Other: ________________________________________ | ☐ Other: ________________________________________ |

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**Pediatrician/Primary Care Physician** ______________________________
**Phone No.** ______________________________
**Fax No**.______________________________
**Office Address** ______________________________

Is the Pediatrician/Primary Care the same as the Referring Physician Yes No
If No, Please Provide the Name and Contact Information for the Referring Physician:

**Referring Physician** ______________________________
**Phone No.** ______________________________
**Fax No.**______________________________
**Office Address** ______________________________

**PATIENT NAME** (first, middle, last) ______________________________ Date of Birth: ______________________________

| **Name of guardian #1:** | **Name of guardian #2:** |
|---|---|
| ______________________________ | ______________________________ |
| *(Last, First, Middle)* | *(Last, First, Middle)* |
| Relationship to patient ______________ | Relationship to patient ______________ |
| 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 ______________ |
| Business phone ______________ | Business phone ______________ |

Person responsible for bill ______________________________

Primary insurance co. name: ______________________________Policy No. ______________________________

Insurance co. address ______________________________
______________________________

Group Name ______________ Group No. ______________ Effective date ______________

Subscriber name ______________ Relationship to patient ______________

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

**X**______________________________ **X**______________________________
(Signature of Patient/Guardian /Date) (Office Official Witness/Date)

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# PATIENT AUTHORIZATION

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 GI**___ 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:

______________________________ ________________________
*Name* *Relationship*

______________________________ ________________________
*Name* *Relationship*

______________________________ ________________________
*Name* *Relationship*

I have read and agree to the above policies.

___________________________________ _________________________
*Patient Name (print)* *Date*

___________________________________
*Signature of Patient/Guardian*

# IMPORTANT REMINDER CHECKLIST

**PLEASE ARRIVE 15 MINUTES PRIOR TO YOUR APPOINTMENT TO COMPLETE THE REGISTRATION PROCESS**

☐ Did you call the PCP's office to have records sent?
*(Last office note, growth chart, labs or related test faxed to (410) 601-5389)*

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

☐ Did you bring the **COMPLETED** New Patient Packet?

☐ Did you bring your state/government issues photo ID, patient's insurance card(s), patient's referral and/or co-pay, if required by insurance?
*(We accept Master Card, Visa, Discover, cash & check)*

☐ 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)*

*****If medical records are not received prior to the appointment, the appointment is subject to being canceled or postponed. *****