GREATER WASHINGTON ORTHOPAEDIC GROUP

Patient's Last, First, MI Date of Birth Age Gender

Name _____ _____ _____ _____ _____ ☐M ☐F

Street Address_____**City & State**_____ **Zip Code** _____ **Marital status:** ____

Home Phone _____ **Cell Phone:** _____ **Email address:** _____

Social Security _____ **Occupation (Indicate if Student):**_____ **How long employed?** _____

Patient's Employer: _____ **Business Phone:** _____

Employer's Address: _____ **City & State:** _____ **Zip Code**_____

Guarantor's Name (Parent-Spouse etc.):_____

Street Address: _____**City & State:** _____ **Zip Code:** _____

Guarantor's Home Phone: _____ **Guarantor's Business Phone:** _____

Guarantor's Employer: _____**Employers Address:** _____

Emergency Contact Name: _____ **Phone #** _____ **Relationship to Patient:** _____

Street Address: _____ **City,State** _____ **Zip Code**_____

If accident, is another party at fault? Yes □ No □ Date of accident/injury: _____

What State did the Accident occur in ☐ MD ☐ VA ☐ DC ☐ other please specify: _____

Referring Physician _____ **Referring Attorney**_____

INSURANCE INFORMATION

Name of Primary Insurance Co._____ **Effective Date:** _____

Policy/ID No._____ **Group No.**_____

Claim Address: _____

Policy Holder's/Subscriber's Name: _____ **Subscriber's Date of Birth**_____

Subscriber's SS# _____ **Relationship to Patient**_____ **Subscriber's Employer:** _____

Subscriber's Employer's Phone _____

Name of Secondary Insurance Co.:_____ **Effective Date**_____

Policy/ID No.:_____ **Group No.:**_____

Claim Address: _____

Policy Holder's/Subscriber's Name: _____ **Subscriber's Date of Birth**_____

Subscriber's SS# _____ **Relationship to Patient**_____ **Subscriber's Employer:** _____

Subscriber's Employer's Phone #_____

INJURY - AUTOMOBILE ACCIDENT

Auto Insurance Co _____ **Claim No.**_____

Adjuster_____ **Adjuster's Phone** _____

Are you the □ Driver □ Passenger □ Pedestrian? **Name of Policy Holder;** _____

Address: _____ **Phone#:**_____

INJURY - WORKER'S COMPENSATION

Worker's Comp. Insurance Co.:_____ **Claim no.**_____

Adjuster: _____ **Adjuster's Phone#:** _____

Claim Address: _____

Employer at time of Injury_____ **Phone#:** _____

Was injury reported to Supervisor? Yes □ No □ **Name of Supervisor:** _____

Patient Signature: _____ Today's Date: _____

Witness Signature: _____ Date: _____

Silver Spring *Rockville* *Olney* *Germantown*

For office use only

Greater Washington Orthopaedic Group, PA

1400 Forest Glen Road, Suite 400
Silver Spring, MD 20910-1482
(301) 589-3324

Agreement To Pay Charges

I understand and agree that:

- It is my responsibility to provide accurate, insurance or other third party payor information to Greater Washington Orthopaedic Group, PA, (GWOG). I understand that as a service to me, GWOG will file my _____ health plan and most insurance or other third party payor claims.
- If the services provided by GWOG are not "covered services" or are not "eligible" for payment under either insurance or other third party coverage due to GWOG's not being a participating or eligible provider, then I am responsible for payment of GWOG's charges, connected with such services; provided that GWOG is not precluded from imposing such charges by the terms of any third party payor agreement to which GWOG is bound, or by applicable law or regulation.
- All co-payments, deductibles, or, unless otherwise specifically agreed by GWOG in writing, outstanding account balances, must be paid at the time of my visit. All charges connected with GWOG's services, not covered by any insurance or other third party coverage are due and payable within 30 days of services rendered. Amounts not paid within such 30 day period shall be deemed to be delinquent and may bear interest at the rate of 1.5% per month (18% per annum). If the delinquent account is referred for collection, I will pay GWOG's attorney's fees, court costs and / or collection agency fees associated with the collection process. If litigation results, the amount of such attorney's fees will be determined by a court and not a jury. This agreement has been executed and delivered in, and shall be interpreted, construed and enforced pursuant to and in accordance with the laws of the State of Maryland without regard to choice of law considerations. The state court forum of any litigation shall be in Montgomery County, Maryland in the court of appropriate jurisdiction, and the federal court jurisdiction will be in the United States District court of Maryland, located in Greenbelt, Maryland.

Assignment of Insurance Benefits and Release of Medical Information

I hereby:

- Assign to GWOG the benefits of _____, and all insurance policies otherwise payable to the patient for services rendered.
- Authorize GWOG to submit insurance claims to _____, other insurance companies or third party payors with respect , to which, GWOG is a participating provider and to apply insurance proceeds or other third party payments for covered services to GWOG and to make refunds to insurance companies or other third party payment plans or rules if refunds are due under the provision of such insurance policies or other third party payment plans or rules.
- Assign all rights, as the insured, to bring an action against my insurance company or other third party payor for benefits due under the insurance policies or their third party payor plans or rules.
- Authorize GWOG to release information and / or copies of the patient's medical records to any guarantor of payment on my account, any insurance company (including worker's compensation carriers and patient's employer) or other third party payor(s) form which benefits may be available.

By Signing my name below, I certify that I have read, understand and agree to the foregoing, received a copy thereof, and am personally empowered, or am duly authorized by the patient, as patient's parent or guardian agent, to execute and enter into the Agreement.

_____ _____

PATIENT NAME (PRINT) **PARENT / GUARDIAN (PRINT)**

_____/_____ _____/_____

PATIENT (SIGNATURE) / DATE **PARENT / GUARDIAN (SIGNATURE) / (DATE)**

_____/_____

Witness (signature) / Date

This agreement *has been approved by Greater Washington Orthopaedic Group and* ***cannot*** *be* ***altered****; text* ***cannot*** *be highlighted, struck through, or obstructed through the use of correction fluids.*

AUTHORIZATION FOR DISCLOSURE OF HEALTH CARE INFORMATION

Patient Information

Patient's Name: _____

Other Name: _____

SSN: _____ Date of Birth_____

Account Number(s) _____ _____ _____

For GWOG use only Account #1 Account #2 Account #3

Authorized Individual Information

I hereby give authorization to Greater Washington Orthopaedic Group, PA to obtain/release healthcare information regarding myself, _____, to/from the party listed below

Name: _____ Fax#: _____

Address: _____

☐ I authorize the release of all information regarding the status of my healthcare, including but not limited to treatment plan(s), & result of radiology test(s), to the person listed above.

☐I authorize the release of all Healthcare information to the person listed above, related to the following treatment, condition, dates, and/or procedure(s) _____

☐ I authorize the release of my billing and/or financial records to the person listed above

☐Other _____

(*Please Specify)*

I understand that Greater Washington Orthopaedic Group may receive compensation for doing so and that if the party receiving this information is not a health care provider or health plan subject to the federal privacy regulation that the information described above may be disclosed and no longer protected by the privacy regulations.

Telephone Contact & Message Authorization

Greater Washington Orthopaedic Group, PA will attempt to contact you via telephone regarding test results and/or appointments, at the phone number(s) you have provided to us. Please indicate below if you permit GWOG to leave voicemail messages containing this information:

☐ I authorize Greater Washington Orthopaedic Group to contact me by telephone

☐ **DO NOT** leave a message on my answering machine ☐ Leave a message on my answering machine

---

I understand that this authorization shall be valid for 1year, unless I revoke this authorization through written notice to Greater Washington Orthopaedic Group, PA at the address listed above.

_____ _____

Patient or Patient's Representative Signature Relationship to Patient

_____ _____

Authorization Date Authorization Expiration Date

_____

Witness

GREATER WASHINGTON ORTHOPAEDIC GROUP, PA

CONFIDENTIAL **Medical History Form**

Personal Information

Patient Last Name: _____ First Name:_____ Middle Initial:_____

Birth Date (MM/DD/YYYY): _____ Age: _____ Sex: □ Male □ Female

Height: _____ Weight: _____ Referring Physician or Attorney _____

Primary Care Physician: _____

Are you currently residing in a nursing home?: □ Yes □ No

Are you currently rehabbing in a skilled nursing facility?: □ Yes □ No

If Yes, to either of the above, where: _____

How did you find us? □ By Referring Physician: □ By Another Patient: □ Other: _____

About your Injury

What are you being seen for today or what hurts?: _____

Did this injury occur at work? □ Yes □ No Were you in an Auto Accident? □ Yes □ No When did symptoms begin? _____

Describe how your injury occurred and your symptoms? _____

_____

What prior treatment have you received for this injury / illness:

Doctor's Name and /or Hospital _____ _____ Date_____

Doctor's Name and/or Hospital _____ Date_____

Doctor's Name and/or Hospital _____ Date_____

List any *prior* injuries you may have had to this same area or body part: _____

Describe when and what treatment you received _____

I have previously or am being treated by a physician for the following conditions: (please check)

Pregnant / could be pregnant • Yes • No

□ High blood pressure	□ Stomach ulcers/gastritis	□ Thyroid problems	□ Bone / Joint problems *
□ High cholesterol	□ Stomach reflux/GERD	□ Kidney problems	□ Rheumatoid arthritis
□ Heart Disease*	□ Irritable bowel syndrome	□ Prostate problems/BPH	□ Osteoporosis/brittle bones
□ Heart attack	□ Asthma	□ Cirrhosis / Liver Disease	□ Stroke/CVA
□ Diabetes	□ Emphysema/COPD	□ HIV/AIDS	□ Neuropathy
□ Blood clot formation/DVT	□ Pulmonary embolus	□ Cancer	□ Depression
□ Blood flow problems/PVD	□ Pneumonia	□ Sleep Apnea	□ Alzheimer's
□ Lung Disease *	□ Hepatitis (A ___ B___ C___)	□ Memory Loss	□ Bladder Disorder
□ Positive TB test			

Do you /Have you suffered from tick bites or Lyme Disease (circle): Yes / No

Other problems that I have (more info) _____

Operations I have undergone in the past ☐ **I have had no major operations in the past**

☐ Appendectomy	☐ Heart surgery	☐ Shoulder surgery
☐ Tonsillectomy	☐ Cardiac catheterization	☐ Knee surgery
☐ Vasectomy	☐ Total Joint Replacement	☐ Previous bone or joint surgery
☐ C-Section	☐ Colonoscopy/endoscopy	☐ Hysterectomy
☐ Myomectomy	☐ Laparoscopy/Laparotomy	☐Other_____

Have you ever had a blood transfusion? Yes _____ No_____ *(If YES give approximate date (s)):*_____

Family and Medical History
***Please check if your blood relative has or had any of the following and indicate which family member by checking the appropriate box* (M = Mother F = Father S = Sister B = Brother)**

	M	F	S	B		M	F	S	B
☐ High blood pressure	☐	☐	☐	☐	☐ Osteoarthritis	☐	☐	☐	☐
☐ High cholesterol	☐	☐	☐	☐	☐ Rheumatoid arthritis	☐	☐	☐	☐
☐ Heart problems/Disease	☐	☐	☐	☐	☐ Other joint problems	☐	☐	☐	☐
☐ Diabetes	☐	☐	☐	☐	☐ Osteoporosis/brittle bones	☐	☐	☐	☐
☐ Asthma	☐	☐	☐	☐	☐ Neuropathy	☐	☐	☐	☐
☐ Bleeding problems	☐	☐	☐	☐	☐ Alzheimer's	☐	☐	☐	☐
☐ Anesthesia problems	☐	☐	☐	☐	☐ Depression	☐	☐	☐	☐
☐ Stroke/CVA	☐	☐	☐	☐	☐ Hepatitis __A __B __C	☐	☐	☐	☐
☐ Bladder Disorder	☐	☐	☐	☐	☐ Thyroid	☐	☐	☐	☐
☐ Kidney Problems	☐	☐	☐	☐	☐ Blood Clots:	☐	☐	☐	☐
☐ Stroke	☐	☐	☐	☐	☐ DVT ☐ Pulmonary Embolus	☐	☐	☐	☐
☐ Emphysema/COPD	☐	☐	☐	☐	☐ Seizure Disorder	☐	☐	☐	☐
☐ Cancer / what type: _____						☐	☐	☐	☐
☐ Other condition :_____						☐	☐	☐	☐

Symptoms / problems** ***Are you having or have you had the following

Muscular / Joint / Bone
- ☐ Ankle(s) L / R
- ☐ Arm(s) L / R
- ☐ Back L / R
- ☐ Elbow(s) L / R
- ☐ Foot / Feet L / R
- ☐ Hand(s) L / R
- ☐ Hip(s) L / R
- ☐ Knee (s) L / R
- ☐ Neck
- ☐ Shoulder(s) L / R
- ☐ Thigh(s) L / R
- ☐ Other: _____

Cardiovascular
- ☐ Swelling in hands / feet
- ☐ Fatigue
- ☐ Pressure on chest
- ☐ Numbness in arms
- ☐ Headaches
- ☐ Palpitations
- ☐ Other _____

Pulmonary
- ☐ Sleep Apnea
- ☐ Shortness of breath
- ☐ Chronic cough
- ☐ Oxygen assisted
- ☐ Chest pain
- ☐ Dizziness
- ☐ Other _____

I am active in

☐ Cycling	☐ Basketball	☐ Gymnastics	☐ Running	☐ Hockey
☐ Walking for fitness	☐ Mountain biking	☐ Golf	☐ Skiing	☐ Swimming
☐ Exercising at the gym	☐ Hiking	☐ Tennis	☐ Snowboarding	☐ Soccer
☐ Weight training	☐ Baseball/Softball	☐ Volleyball	☐ Dance/cheer	☐ Lacrosse
☐ No specific sport or exercise				

Other physical activities _____

Social History

Alcohol Use	**Tobacco Use**	**Recreational Drug Use**
☐ None/Rarely	☐ I don't smoke	☐ None
☐ 1-2 drinks/week	☐ I quit in _____ after smoking	☐ Occasionally
☐ 1-2 drinks/day	_____packs/day for _____ year's	☐ Regularly
☐ Three or more drinks/day	☐ ½ to 1 pack/day	☐ Drugs I commonly use:_____
	☐ 2 or more packs/day	_____

☐ Difficulty with heavy alcohol use in the past / When did you stop? _____

Review of symptoms – These are symptoms I commonly experience (check only if yes)

Endocrinology
- ☐ Frequent thirst
- ☐ Frequent Hunger
- ☐ Hyperactivity
- ☐ Hypoactivity
- ☐ Growth / Hair changes

Describe: _____

Ear / Nose / Throat
- ☐ Decreased hearing
- ☐ Ringing in the ears
- ☐ Dizziness
- ☐ Hoarseness
- ☐ Sinusitis

Describe: _____

Neurologic
- ☐ Headaches
- ☐ Speech difficulty
- ☐ Stroke/TIA
- ☐ Numbness, tingling
- ☐ Seizures/epilepsy
- ☐ Balance problems, falls

Describe: _____

Constitutional
- ☐ Fever
- ☐ Fatigue
- ☐ Unexplained weight loss
- ☐ Weakness all over

Describe: _____

Lymphatic
- ☐ Bleeding tendency
- ☐ Easy bruising
- ☐ Lymph node enlargement
- ☐ Anemia

Describe: _____

Eyes
- ☐ Double vision
- ☐ Blurry vision
- ☐ Eye trauma
- ☐ I wear glasses/contacts

Describe: _____

Cardiology
- ☐ Chest pain
- ☐ Heart palpitations
- ☐ Rapid heartbeats
- ☐ Irregular heartbeats
- ☐ High blood pressure

Describe: _____

Gastro Intestinal
- ☐ Abdominal pain
- ☐ Nausea
- ☐ Stomach ulcers/reflux
- ☐ Heartburn/indigestion
- ☐ Appetite change
- ☐ Change in bowel habits
- ☐ Diarrhea
- ☐ Constipation

Describe: _____

Psychological
- ☐ Mood swings
- ☐ Sleep problems
- ☐ Depression
- ☐ Anxiety
- ☐ Substance abuse
- ☐ Alcoholism

Describe: _____

Epidemiology
- ☐ Changes in skin color
- ☐ Loss of appetite
- ☐ Skin rashes
- ☐ Skin masses
- ☐ Skin sores/ulcers
- ☐ Skin cancers

Describe: _____

Musculoskeletal
- ☐ Bone fractures
- ☐ Joint sprains
- ☐ Joint swelling
- ☐ Low back pain
- ☐ Joint stiffness
- ☐ Osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ Fibromyalgia

Describe: _____

Pulomonary
- ☐ Shortness of breath
- ☐ Asthma
- ☐ Bronchitis
- ☐ Chronic lung problems
- ☐ Chronic cough

Describe: _____

Bladder
- ☐ Difficulty passing urine
- ☐ Incontinence
- ☐ Frequent urination
- ☐ Urinary tract infections

Describe: _____

Reproductive
- ☐ Painful menstruation/PMS/PMDD
- ☐ Menopause
- ☐ Hemoragic
- ☐ Endomitriosis

Describe: _____

Allergies
- ☐ Latex / Rubber gloves
- ☐ Medical tape
- ☐ Seasonal Allergies
- ☐ Food Allergies

Describe: _____

To the best of my knowledge, the above information is complete and accurate. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have changes in health status.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative *Date*

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative *Relationship to patient*

_____ _____ _____

Signature of reviewing physician *Print Name* *Date*

MEDICATIONS ***PLEASE LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING (ATTACH SEPARATE SHEET IF NECESSARY)***

MEDICATION NAME________________________________ DOSAGE ____ FREQUENCY______________________________________ PRESCRIBING PHYSICIAN___________________________ CONDITION/REASON ____________________________	MEDICATION NAME________________________________ DOSAGE ____ FREQUENCY______________________________________ PRESCRIBING PHYSICIAN___________________________ CONDITION/REASON ____________________________
MEDICATION NAME________________________________ DOSAGE ____ FREQUENCY______________________________________ PRESCRIBING PHYSICIAN___________________________ CONDITION/REASON ____________________________	MEDICATION NAME________________________________ DOSAGE ____ FREQUENCY______________________________________ PRESCRIBING PHYSICIAN___________________________ CONDITION/REASON ____________________________
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MEDICATION NAME________________________________ DOSAGE ____ FREQUENCY______________________________________ PRESCRIBING PHYSICIAN___________________________ CONDITION/REASON ____________________________	MEDICATION NAME________________________________ DOSAGE ____ FREQUENCY______________________________________ PRESCRIBING PHYSICIAN___________________________ CONDITION/REASON ____________________________

Please list any vitamins or supplements that you take: __________________ __________________ __________________

__________________ __________________ __________________ __________________ __________________

Allergies I have to Medications/Anesthesia

Medications
Are you allergic to any medications? Yes____ No_____

Please list Medications that you are allergic to: ________________

____

____

Please circle the type of reaction you have: *Rash, Nausea*
*Stopped breathing other (please explain)*________________________

Anesthesia
Are you allergic to any anesthesia? Yes____ No_____

Please list Anesthetics that you are allergic to: ______________

____

____

Please circle the type of reaction you have: *Rash Nausea*
*Stopped breathing other (please explain)*__________________________

______________________________________ ______________________ ____________________
Patient / Guarantor Signature Date of Origination M/A Initials