

GREATER WASHINGTON ORTHOPAEDIC GROUP, P.A.
PATIENT INFORMATION

Patient's Name (Last, First, Middle Initial)		Gender	Date of Birth	Age	Social Security	Marital Status
Street Address			City & State	Zip Code	Home Phone	
Patient's Employer		Occupation (Indicate if Student)			How long employed?	
Employer's Address			City & State	Zip Code	Business Phone	
Guarantor's Name (Parent-Spouse etc.)	Street Address	City & State	Zip Code	Home Phone	Relationship to Patient	
Guarantor's Employer		Employers Address			Business Phone	
Emergency Contact	Street Address	City & State	Zip Code	Phone #	Relationship to Patient	
Representing Attorney		Referring/Primary Care Physician				
Date of accident/injury		How and Where did incident occur?				

If accident, is another party at fault? Yes No What State did the Accident Occur In MD VA DC
 Other please specify : _____

INSURANCE INFORMATION

Name of Primary Insurance Co.		Effective Date	Policy/ID No.	Group No.
Address				
Subscriber's Name	Subscriber's Date of Birth	Subscriber's Social Security #	Relationship to Patient	
Subscriber's Employer		Subscriber's Employer's Phone #		
Name of Secondary Insurance Co.		Effective Date	Policy/ID No.	Group No.
Address				
Subscriber's Name	Subscriber's Date of Birth	Subscriber's Social Security #	Relationship to Patient	
Subscriber's Employer		Subscriber's Employer's Phone #		

Have you or any member of your immediate family been treated by our physician's before? Yes No
 If yes, Patient's Names: _____ Name of Physician: _____

INJURY - AUTOMOBILE ACCIDENT

Auto Insurance Co	Claim No.	Adjuster	Adjuster's Phone #
Address			Are you the Driver <input type="checkbox"/> or Passenger <input type="checkbox"/> ?
Name of Policy Holder	Address	Phone#	

INJURY - WORKER'S COMPENSATION

Worker's Comp. Insurance Co.	Claim No.	Adjuster	Adjuster's Phone#
Address			
Employer at Time of Injury	Address	Phone #	

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

Silver Spring Rockville Olney Germantown

Today's Date: _____

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PATIENT'S AUTHORIZATION

I, _____ hereby authorize Greater Washington Orthopaedic Group, P.A. to apply for benefits on my behalf for covered services rendered. I request payment from BC/BS NCA, Medicare, and/or _____ be made directly to Greater Washington Orthopaedic Group, P.A. I certify that the information I have reported with regard to my insurance coverage is correct, and I further authorize the release of any necessary information, including medical information, for this, or related claim, to the above-named billing agent and/or _____. I permit a copy of this authorization to be used in place of the original. I agree to waive the 3-year statute of limitations in the event a claim is made against me for an unpaid bill and to be responsible for interest at a rate of 1.5% per month, attorney's fees in the amount of 25% of the outstanding principal balance, and court costs if my account is turned over to any attorney for collection. For automobile accident-related cases, Greater Washington Orthopaedic Group has no written contract with any automobile insurance carrier. In the event that my automobile insurance company does not pay my account in full, I understand that I am responsible for the entire balance.

If this is a claim for a work-related injury or a condition covered under Worker's Compensation insurance, I understand that I am responsible for the bill until a valid claim number is provided for this injury. It is my responsibility to obtain this claim number and to provide this claim number to the billing office of Greater Washington Orthopaedic Group.

It has been explained to me, and I understand, that my doctor may prescribe services or supplies that, while they require no prior authorization, may be retroactively denied by my insurance company as "not medically necessary." In the event this should happen, I agree to be fully responsible for the balance due.

SIGNATURE OF SUBSCRIBER _____ DATE _____

WITNESS _____ DATE _____

COMPLETE IF AN ATTORNEY IS REPRESENTING YOU FOR YOUR INJURY*

Attorney's Name _____ Attorney's Phone _____

Attorney's Address _____
Street Suite # City State Zip

***Ask receptionist for an "Authorization and Assignment" form**

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MEDICAL HISTORY

Patient Name: _____

Present Problem (Purpose of Visit) _____ Started on/or about _____

Briefly Describe Problem If related to an accident or injury:

Were you treated for this problem elsewhere? Yes No By Whom? _____

Current Health Problems		Past Serious Illness		Family History		
Do you have		Did you have				
Yes	No	Yes	No	Yes	No	
-	-	-	-	-	-	Diabetes
-	-	-	-	-	-	Cancer
-	-	-	-	-	-	TB
-	-	-	-	-	-	Arthritis
-	-	-	-	-	-	Heart Disease
-	-	-	-	-	-	Other _____

Are you taking Medication presently?
Yes No
Please list.

Are you allergic to any Medication?
Yes No
Please list.

Do you smoke?
Yes No
How many packs/day

Please list any prior surgical procedures you have had _____

Do you take vitamins or herbal preparations ? Yes _ No _ If so, which one(s)? _____
Are you a Vegetarian? Yes _ No _

To my knowledge, the above information is true and correct.

Patient's Signature: _____ Date: _____

This Space for office use only

Patient History taken by: _____

Patient History reviewed by _____

Updated Patient History taken by: _____

Updated Patient History reviewed by: _____

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RELEASE OF INFORMATION

I understand that HIPAA has implemented procedures that require specific authorization for release of my information. I agree to the following statements and understand that I can revoke these at any time, by informing Greater Washington Orthopaedic Group, P.A. in writing.

Home or cellular telephone #: We may leave a message with a callback number regarding administrative, health issues or requests; or a reminder of your appointment on voicemail. _____

Work telephone #: We may leave a message with a callback number regarding administrative, health issues or requests; or a reminder of your appointment on voicemail. _____

Written communication: We may mail postcards to your home address or send you an email if applicable. _____

Print Name: _____

Patient Signature: _____

Date: _____

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Use & Disclosure of Protected Health Information

The Greater Washington Orthopaedic Group's "Notice of Privacy Practice" provides information about how we may use and disclose protected health information about you. Please acknowledge receipt of this office's Notice of Privacy Practices by initialing below:

Patient's Initial

Our Notice of Privacy Practices states that we reserve the right to change the terms described. Should this happen, you will receive a revised copy by mail (*or explain your discretionary terms*)

Patient's Initial

You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required agree to your restrictions, but if we do, we are bound by our agreement with you.

Patient's Initial

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, or health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in trust on your prior consent.

Signature

Date