

Greater Washington Orthopaedic Group, PA

Office :(301) 589-3324

Fax: (301) 681-7575

Silver Spring

1400 Forest Glen Road, Suite 400
Silver Spring, MD 20910

Olney

18111 Prince Philip Drive, Suite 221
Olney, MD 20832

Rockville

9420 Key West Ave. Suite 400
Rockville, MD 20850

Germantown

19532 Doctors Drive
Building 1, Door #2
Germantown, MD 20874

To: Our New Patient...

Welcome to our practice!

We are honored to have an opportunity to meet your Orthopaedic needs. Enclosed you will find your new patient paperwork. Please review and completely fill out the enclosed documents and bring them with you to your upcoming appointment.

Your appointment is with:

On: _____ at : _____ am/pm. In: _____

We will also **need** the following: (*must have at the time of visit*)

1. A picture ID (drivers license, passport, etc)
2. Your health insurance card
3. A referral (if your insurance plan requires one)
4. Your actual X-ray and/or MRI films or disc (if you had these tests)
5. Your "Specialist" visit co pay
6. A written or typed list of **all** medications (with dosage) you are currently taking
7. If work related, your claim number and insurance carrier. If none of these are available, please bring a copy of your injury report.
8. Nursing home and rehabilitation facility patients, please bring X-rays from your facility, and have a responsibility party complete forms prior to your appointment

If you have any questions or need assistance, please call the office and we will be happy to help you. If you need to reschedule your appointment, please do so within 48 hours or with as much notice as you can to allow us to schedule another patient in your time slot if needed.

We look forward to seeing you soon

Sincerely,

Registration Department

DIRECTIONS

Directions to our Silver Spring office:

The Silver Spring office is located at Holy Cross Hospital, in the Physician Specialist Wing. It can be reached from Georgia Avenue. If you are coming from the direction of Wheaton, Rockville, or other points north, take Veirs Mill Road to Georgia Avenue then proceed south for approx. 2 miles, until you reach Forest Glen Road. Turn left onto Forest Glen Road and proceed to the Hospital Campus, which will be on the right.

Please note: A left turn onto Forest Glen Road is restricted before 9:30 a.m. If arriving before 9:30 a.m., proceed south on Georgia and turn left at the light at Dennis Avenue. Follow Dennis Ave. to a 4-way stop at Sligo Creek Parkway. Turn right onto Sligo Creek Parkway, and then turn right at the light at Forest Glen and Sligo Creek Parkway. The Hospital Campus will be on the left.

- Coming from the I-95, or the Capital Beltway, take Exit 31A to Georgia Avenue North, going towards Wheaton, for .3 miles. Turn right onto Forest Glen Road.
- From points north, take Georgia Avenue south from Wheaton, to Forest Glen Road. Turn left onto Forest Glen Road, and go to 1400 Forest Glen Road.

Directions to our Rockville office:

Directions from the North

From I-270 south take exit 8b / Shady Grove Road, proceed approximately 1-mile, and then turn right onto Key West Avenue. Make an immediate left into the parking lot. The building at the back of the parking lot will be 9420 Key West Avenue, Suite 400.

Directions from the South

From Capital Beltway (495) take exit 35 / I-270 north toward Rockville and Frederick. Keep right to take I-270 local lanes. Take exit 6b / MD-Route 28 west toward Darnstown, MD. This will become Key West Avenue. Proceed approximately 2-miles then continue across Shady Grove Road and make an immediate left into the parking lot. 9420 Key West Avenue, Suite 400 will be the building at the back of the parking lot. From I-270 south, take exit 8B / Shady Grove Road

Directions to our Olney office:

Our Olney office is located on Prince Philip Drive, next to Montgomery General Hospital. Olney can be reached if you are coming from Rockville Pike, by taking Rt. 28, east, (which is also Norbeck Road). Go a few miles, and at the intersection of Norbeck and Georgia Avenue, make a left onto Georgia Avenue. Go straight on Georgia towards Olney, and make a right turn onto Prince Philip Drive (just after Old Baltimore Road). Or, go up to the intersection of Route 108 (Sandy Spring Road and Georgia Avenue.) Make a right at the stop light in the heart of Olney. Go a couple of blocks, and you will make a left onto Prince Philip Drive here. The road curves around to the left and the Physician's Office Center will be on your right, where you can turn into the parking lot.

Directions to our Germantown office:

From I-270, take Exit 15 B, Route 118 South. At the 5th traffic light, make a left onto Wisteria Drive. At the following intersection, make a right onto Walter Johnson. You will pass our building on your left. Make a left into the parking lot.
We are located in Building 1, Door #2

GREATER WASHINGTON ORTHOPAEDIC GROUP, PA
CONFIDENTIAL **Medical History Form**

Personal Information

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

Birth Date (MM/DD/YYYY): _____ Age: _____ Sex: Male Female
Height: _____ Weight: _____ Referring Physician or Attorney _____
Primary Care Physician: _____

Do you currently reside or have resided in a nursing home 30 days or more: Yes No

If yes, where:

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

About your Injury

Describe: _____

Muscular/Joint/Bone

Ankle(s) L/R Hip(s) L/R Arm(s) L/R Knee(s) L/R Back Leg(s) L/R Elbow L/R Neck
Feet L/R Shoulder(s) L/R Hand(s) L/R Thigh(s) L/R

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

Describe your symptoms?

What prior treatment have you received?

Doctor's Name and /or Hospital _____ Date _____

Doctor's Name and/or Hospital _____ Date _____

Current Health

Medical conditions that I have

No medical conditions that I know of

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Pregnant or could be pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Stomach ulcers/gastritis | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Stomach reflux/GERD | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Irritable bowel syndrome | <input type="checkbox"/> Prostate problems/BPH | <input type="checkbox"/> Osteoporosis/brittle bones |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Asthma | <input type="checkbox"/> Liver problems/hepatitis | <input type="checkbox"/> Stroke/CVA |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Emphysema/COPD | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Neuropathy |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pulmonary embolus | <input type="checkbox"/> Cancer | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Blood clot formation/DVT | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Alzheimer's |
| <input type="checkbox"/> Blood flow problems/PVD | | | |

Other medical problems I have/more info: _____

Allergies I have to Medications/Anesthesia

I have no known allergies to any medications

Type of reaction (rash, nausea, stopped breathing, etc.)

I have known allergies to anesthesia

Operations I have undergone in the past I have had no major operations in the past If yes, describe:

- | | | |
|--|--|---|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Heart surgery | <input type="checkbox"/> Shoulder surgery |
| <input type="checkbox"/> Tonsillectomy | <input type="checkbox"/> Cardiac catheterization | <input type="checkbox"/> Knee surgery |
| <input type="checkbox"/> Vasectomy | <input type="checkbox"/> Total Joint Replacement | <input type="checkbox"/> Previous bone or joint surgery |
| <input type="checkbox"/> C-Section | <input type="checkbox"/> Colonoscopy/endoscopy | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Myomectomy | <input type="checkbox"/> Laprascopy/Laprarotomy | <input type="checkbox"/> Other _____ |

Family and Medical History No medical problems in my family that I know of

- | Medical problem: | In my (mother, father, etc.): | Medical problem: | In my (mother, father, etc.): |
|---|--------------------------------------|--|--------------------------------------|
| <input type="checkbox"/> High blood pressure | | <input type="checkbox"/> Osteoarthritis | |
| <input type="checkbox"/> High cholesterol | | <input type="checkbox"/> Rheumatoid arthritis | |
| <input type="checkbox"/> Heart problems/Disease | | <input type="checkbox"/> Other joint problems | |
| <input type="checkbox"/> Diabetes | | <input type="checkbox"/> Osteoporosis/brittle bones | |
| <input type="checkbox"/> Asthma | | <input type="checkbox"/> Neuropathy | |
| <input type="checkbox"/> Bleeding problems | | <input type="checkbox"/> Alzheimer's | |
| <input type="checkbox"/> Anesthesia problems | | <input type="checkbox"/> Cancer | |
| <input type="checkbox"/> Stroke/CVA | | <input type="checkbox"/> Depression | |
| <input type="checkbox"/> Bladder Disorder | | <input type="checkbox"/> Hepatitis __A __B __C | |
| <input type="checkbox"/> Kidney Problems | | <input type="checkbox"/> Thyroid | |
| <input type="checkbox"/> Stroke | | <input type="checkbox"/> Blood Clots <input type="checkbox"/> DVT <input type="checkbox"/> Pulmonary Embolus | |
| <input type="checkbox"/> Seizure Disorder | | <input type="checkbox"/> Other: _____ | |
| <input type="checkbox"/> Emphysema/COPD | | | |

I am active in

- | | | | | | |
|--|--|-------------------------------------|---------------------------------------|-----------------------------------|---------------------------------|
| <input type="checkbox"/> No specific sport or exercise | <input type="checkbox"/> Cycling | <input type="checkbox"/> Basketball | <input type="checkbox"/> Gymnastics | <input type="checkbox"/> Running | <input type="checkbox"/> Hockey |
| <input type="checkbox"/> Walking for fitness | <input type="checkbox"/> Mountain biking | <input type="checkbox"/> Golf | <input type="checkbox"/> Skiing | <input type="checkbox"/> Swimming | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Exercising at the gym | <input type="checkbox"/> Hiking | <input type="checkbox"/> Tennis | <input type="checkbox"/> Snowboarding | <input type="checkbox"/> Soccer | |
| <input type="checkbox"/> Weight training | <input type="checkbox"/> Baseball/Softball | <input type="checkbox"/> Volleyball | <input type="checkbox"/> Dance/cheer | <input type="checkbox"/> Lacrosse | |

Social History

Alcohol Use

- None/Rarely
- 1-2 drinks/week
- 1-2 drinks/day
- Three or more drinks/day
- Difficulty with heavy alcohol use in the past
When did you stop? _____

Tobacco Use

- I don't smoke
- I quit in _____ after smoking
_____ packs/day for _____ year's
- ½ to 1 pack/day
- 2 or more packs/day
When did you stop? _____

Recreational Drug Use

- None
- Occasionally
- Regularly
- Drugs I commonly use:

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

- Seasonal allergies/hay fever
- Dermatitis
- Frequent itching
- Skin reactions
- Reactions to Latex/rubber gloves
- Runny nose

Describe: _____

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

Describe: _____

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

Describe: _____

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

Describe: _____

- Frequent thirst
- Frequent Hunger
- Hyperactivity
- Hypoactivity
- Growth changes
- Hair changes

Describe: _____

- Decreased hearing
- Ringing in the ears
- Dizziness
- Hoarseness
- Sinusitis

Describe: _____

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

Describe: _____

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

Describe: _____

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

Describe: _____

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

Describe: _____

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

Describe: _____

- Mood swings
- Sleep problems
- Depression
- Anxiety
- Substance abuse
- Heavy alcohol use/drinking

Describe: _____

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

Describe: _____

- Difficulty passing urine
- Incontinence
- Frequent urination
- Urinary tract infections
- Painful menstruation/PMS

Describe: _____

Preferred Pharmacy Name: _____ Telephone No.: _____

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

AUTHORIZATION FOR DISCLOSURE OF HEALTH CARE INFORMATION

Patient Information

Patient's Name: _____

Other Name: _____

SSN: _____ Date of Birth _____

GWOG Account Number(s): _____
Account #1 Account #2 Account #3

Authorized Individual Information

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

Name: _____

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 tests, 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 I year, 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

Witness

Authorization Date

Authorization Expiration Date

GREATER WASHINGTON ORTHOPAEDIC GROUP

Patient's Last,	First,	MI	Date of Birth	Age	Gender
Name _____	_____	_____	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F
Street Address _____	City & State _____	Zip Code _____	Home Phone _____		
Cell Phone: _____	Patient's Employer: _____				
Occupation (Indicate if Student): _____	how long employed? _____	Social Security _____			
Employer's Address: _____	City & State: _____	Zip Code _____			
Business Phone: _____	Guarantor's Name (Parent-Spouse etc.): _____				
Street Address: _____	City & State: _____	Zip Code: _____			
Home Phone: _____	Guarantor's Employer: _____				
Employers Address: _____	Business Phone: _____				

Emergency Contact Name: _____	Relationship to Patient: _____
Street Address: _____	City, State _____ Zip Code _____
Phone # _____	
Representing Attorney _____	If accident, is another party at fault? Yes <input type="checkbox"/> No <input type="checkbox"/>
What State did the Accident occur in <input type="checkbox"/> MD <input type="checkbox"/> VA <input type="checkbox"/> DC <input type="checkbox"/> other please specify: _____	

INSURANCE INFORMATION

Name of Primary Insurance Co. _____	Effective Date: _____
Policy/ID No. _____	Group No. _____
Claim Address: _____	
Policy Holder's/Subsriber'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/Subsriber'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 or Passenger ? 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: _____

Silver Spring Rockville Olney Germantown

Patient Signature: _____

today's Date: _____