

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 <input type="checkbox"/> No <input type="checkbox"/>			In what State did the Accident Occur? <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.
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 any of our physician's before? Yes <input type="checkbox"/> No <input type="checkbox"/>				
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 <input type="checkbox"/> No <input type="checkbox"/>		Name of Supervisor:		

Silver Spring Rockville Olney Germantown

Today's Date: _____

**GREATER WASHINGTON ORTHOPAEDIC GROUP, P.A.
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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. Payment is due at the time services are rendered. As a courtesy we will bill your health insurance, however, you are still responsible for your bill. In the event payment is not received from an insurance provider, GWOG will inform me of that fact and payment from me will be required at that time. In the event payment is not forthcoming from me and they turn this matter over to an attorney for collections, I agree to be responsible for interest at the rate of 1.5% per month from the date I was informed payment was expected from me, attorney's fees in the amount of 25% of the outstanding principal balance and any actual court costs incurred. 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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**GREATER WASHINGTON ORTHOPAEDIC GROUP, P.A.
PATIENT ACKNOWLEDGMENT FORM**

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient _____ Phone _____ Account # _____
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I understand The Greater Washington Orthopaedic Group's "Notice of Privacy Practice" provides information about how my personal protected health information may be used.

Initials _____

I understand the Notice of Privacy Practices states that I reserve the right to change the terms described. Should this happen, I will receive a revised copy by mail (or will explain my discretionary terms)

I understand I have the right to request restrictions on how my protected health information may be used or disclosed for treatment, payment, or health care operations and Greater Washington Orthopaedic Group is not required to agree to my restrictions, but if so, will be bound by the agreement with you.

I agree that a message can be left at my home or cellular telephone number with a callback number regarding administrative, health issues or requests; or a reminder of my appointment on voice-mail.

I agree that a message can be left at my work telephone number regarding administrative, health issues or requests; or a reminder of my appointment on voice-mail.

I agree that communication can be mailed to my home address or sent by email if applicable.

I authorize Greater Washington Orthopaedic Group to use/disclose information to:

● _____
recipients name, address, phone, and/or fax

● _____
description of information to be used or disclosed (ie:medical records, x-rays/MRIs)

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 regulations that the information described above may be disclosed and no longer protected by the privacy regulations.

I further understand that I may revoke this authorization in writing at any time except to the extent that action on the authorization has not already occurred. And the authorization becomes effective on _____ and will expire on _____, and that I may refuse to sign this authorization, and that if I do, it will not affect my ability to obtain treatment or payment or eligibility of benefits and that I may inspect or copy the information being used or disclosed under this authorization.

PATIENT / REPRESENTATIVE/GUARDIAN

DATE

PRINTED NAME OF REPRESENTATIVE/GUARDIAN

RELATIONSHIP

GREATER WASHINGTON ORTHOPAEDIC GROUP, P.A.
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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

Do you have

Yes No

- Heart Trouble
- Diabetes
- High Blood Pressure
- Kidney Disease
- Digestive Ulcers
- Other _____

Past Serious Illness

Did you have

Yes No

- Rheumatic Fever
- Tuberculosis
- Polio
- Hepatitis
- Cancer
- Other _____

Family History

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: _____