

# OrthoBethesda

J. Patrick Caulfield, M.D. • Edward J. Bieber, M.D. • Ira D. Fisch, M.D.  
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## Patient Registration

Please Print

This information is required by insurance companies.

Chart # \_\_\_\_\_

PATIENT NAME: First Middle Last		HOME PHONE ( )	
ADDRESS: Street Apt. # City State Zip Code		WORK / SCHOOL PHONE ( )	
GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH	AGE	MARITAL STATUS
OCCUPATION		SOCIAL SECURITY NUMBER ( )	
EMERGENCY CONTACT NAME		PATIENT'S EMPLOYER / SCHOOL NAME AND ADDRESS	
RELATIONSHIP TO PATIENT		PHONE NUMBER ( )	
<b>If patient is under 18 years of age, please complete the following:</b>			
ACCOMPANYING ADULT'S NAME		SIGNATURE	
<b>If patient is staying at a Skilled Nursing Facility, please complete the following:</b>			
FACILITY NAME		FACILITY ADDRESS	
FACILITY PHONE NUMBER ( )			
<b>PERSON FINANCIALLY RESPONSIBLE (if other than patient):</b>			
NAME		PATIENT'S RELATIONSHIP TO RESPONSIBLE PARTY	
		<input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other _____	
HOME PHONE NUMBER ( )		WORK PHONE NUMBER ( )	
<b>CONDITION INFORMATION</b>			
INJURED BODY PART		DATE PROBLEM BEGAN OR OF THE MOST RECENT FLARE-UP	
SIDE <input type="checkbox"/> Right <input type="checkbox"/> Left			
PRIMARY CARE PHYSICIAN'S NAME		REFERRING <b>PHYSICIAN</b> , IF DIFFERENT	
AUTO ACCIDENT? <input type="checkbox"/> Yes <input type="checkbox"/> No	STATE	WORK-RELATED ACCIDENT? <input type="checkbox"/> Yes <input type="checkbox"/> No	STATE
OTHER ACCIDENT? <input type="checkbox"/> Yes <input type="checkbox"/> No		DATE OF ACCIDENT	
IS AN ATTORNEY HANDLING THIS CASE? <input type="checkbox"/> Yes <input type="checkbox"/> No		NAME AND TELEPHONE NUMBER OF ATTORNEY ( )	
DO YOU HAVE A LIVING WILL? <input type="checkbox"/> Yes <input type="checkbox"/> No			
PLEASE CHECK APPROPRIATE BOX <b>HEALTH</b> <input type="checkbox"/> <b>PIP / AUTO</b> <input type="checkbox"/> <b>WORKERS COMP</b> <input type="checkbox"/> <b>SELF-PAY</b> <input type="checkbox"/>			
<b>PRIMARY INSURANCE</b>			
INSURANCE COMPANY NAME		POLICY NUMBER	
GROUP NUMBER		EFFECTIVE DATE	
INSURANCE COMPANY PHONE ( )			
INSURANCE ADDRESS: Street City State Zip Code		POLICY IN NAME OF	
PATIENT'S RELATIONSHIP TO INSURED		INSURED'S SOCIAL SECURITY #	
INSURED'S DATE OF BIRTH		INSURED'S GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	
INSURED'S EMPLOYER NAME			
<b>SECONDARY INSURANCE</b> <input type="checkbox"/> <b>Medigap</b> <input type="checkbox"/> <i>Please Check</i>			
INSURANCE COMPANY NAME		POLICY NUMBER	
GROUP NUMBER		EFFECTIVE DATE	
INSURANCE COMPANY PHONE ( )			
INSURANCE ADDRESS: Street City State Zip Code		POLICY IN NAME OF	
PATIENT'S RELATIONSHIP TO INSURED		INSURED'S SOCIAL SECURITY #	
INSURED'S DATE OF BIRTH		INSURED'S GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	
INSURED'S EMPLOYER NAME			

### Patient Acknowledgment

I certify that the information I have reported above is true and correct. I authorize the release of any necessary information, including medical information, for this or any related claim to my insurance company in order to determine payable benefits. I request that payment of authorized benefits be made payable to OrthoBethesda on my behalf. I will notify this office of any changes in my health insurance coverage.

\_\_\_\_\_  
Signature of Patient, Policy Holder or Legal Guardian

\_\_\_\_\_  
Date

Printed Name: \_\_\_\_\_

I have received a copy of the Notice of Privacy Practices for OrthoBethesda.

I have been offered a copy of the Notice of Privacy Practices for OrthoBethesda but did not want a copy.

**Please read and sign the back of this form.**

**ORTHOBETHESDA**

J. PATRICK CAULFIELD, M.D.  EDWARD J. BIEBER, M.D.  IRA D. FISCH, M.D.  
 KURT C. SCHLUNTZ, M.D.  ANDRE R. GAZDAG, M.D.  CHRISTOPHER J. CANNOVA, M.D.  THERAPY SERVICES

**CLINICAL INFORMATION SHEET** - Your insurance company **requires** that we obtain this information. Please fill out **completely!**

PATIENT'S NAME \_\_\_\_\_ HEIGHT: \_\_\_\_\_ ft. \_\_\_\_\_ in. WEIGHT \_\_\_\_\_ AGE \_\_\_\_\_

PRIMARY CARE (REFERRING) \_\_\_\_\_ REFERRING **PHYSICIAN**  
**PHYSICIAN** \_\_\_\_\_ IF DIFFERENT \_\_\_\_\_

**WE WILL SEND OFFICE NOTES TO THE ABOVE PHYSICIANS UNLESS OTHERWISE DIRECTED**

**ARE YOU STAYING AT A SKILLED NURSING FACILITY?** \_\_\_\_\_ **WHERE?** \_\_\_\_\_

**MEDICAL HISTORY:** Please circle if you have, or have had, any of the following:  NONE

- |                      |                           |                     |                          |                              |
|----------------------|---------------------------|---------------------|--------------------------|------------------------------|
| 1. Diabetes          | 4. Heart Arrhythmia       | 7. Heart Attack     | 10. Rheumatoid Arthritis | 13. Stomach/Duodenal Cancer  |
| 2. Stroke            | 5. Coronary Heart Disease | 8. High Cholesterol | 11. Liver Disease        | 14. Gastro/Esoph/Acid Reflux |
| 3. TIA (mini stroke) | 6. High Blood Pressure    | 9. Depression       | 12. Kidney Disease       | 15. Cancer (type) _____      |
|                      |                           |                     |                          | 16. Osteoarthritis           |

**OTHER** \_\_\_\_\_

**SURGICAL PROCEDURES:** Have you ever had any surgery?  YES  NO If yes, please circle:  
1. Heart Surgery 3. Vascular Bypass 5. Angioplasty 7. Appendectomy 9. Carotid Endarterectomy  
2. Hernia Repair 4. Hysterectomy 6. Cancer Surgery \_\_\_\_\_ 8. Gallbladder Surgery Date of Surgery: \_\_\_\_\_

Please list any *orthopaedic surgeries* you have had: \_\_\_\_\_

**REVIEW OF SYMPTOMS:** Are you currently having, or have you ever had, problems with:  NONE  
Lungs or Breathing?  Yes  No Bleeding Disorders?  Yes  No Heart or Chest Pain?  Yes  No  
GI Ulcers?  Yes  No Numbness or Tingling?  Yes  No

**SOCIAL HISTORY:**  
Do you smoke?  Yes  No Do you drink alcohol?  Yes  No Do you exercise regularly?  Yes  No

**MEDICATIONS:** Do you take any medications, including aspirin and other non-prescription medications?  Yes  No  
If yes, please list: \_\_\_\_\_

**ALLERGIES:** Are you allergic to any medications, environmental substances, or metals?  Yes  No If yes, please list. \_\_\_\_\_

**WHAT PART OF THE BODY ARE YOU HERE FOR TODAY?** \_\_\_\_\_  LEFT  RIGHT  
**WHEN DID THIS PROBLEM BEGIN?\*** \_\_\_\_\_

\*IF ONGOING, PLEASE INDICATE TIME PERIOD OF MOST RECENT EPISODE OR "FLARE-UP:" \_\_\_\_\_

**WAS THERE A SPECIFIC INJURY?**  Yes  No If yes, briefly describe incident: **HOME WORK OTHER**

**PAST HISTORY** – Have you had previous problems with this area?  Yes  No  
If yes, please describe: \_\_\_\_\_

**HAVE YOU SEEN ANY OTHER PHYSICIANS FOR THIS PROBLEM?**  Yes  No Physician \_\_\_\_\_

WERE X-RAYS TAKEN?  Yes  No IF YES, DID YOU BRING THE X-RAYS WITH YOU?  Yes  No

WERE ANY OTHER TESTS PERFORMED?  Yes  No IF YES, DID YOU BRING THE TEST RESULTS WITH YOU?  Yes  No

**IF FEMALE:** IS THERE ANY POSSIBILITY THAT YOU ARE PREGNANT?  Yes  No

\* The above is true and correct to the best of my knowledge.

**PATIENT SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

REVIEWED BY \_\_\_\_\_ **DATE** \_\_\_\_\_

## Patient Financial Policy & Consent to Treatment

We are committed to providing you with the best possible care, and will help you receive your maximum allowable insurance benefits. We need *your* assistance and *your* understanding of our payment policy. Your insurance contract is between you, your employer and the insurance company. Not all services are covered by all contracts. While the filing of insurance claims for participating insurance carriers is a contractual obligation of the Practice, all fees are ultimately the patient's responsibility. We will be happy to help you process your insurance claim form for reimbursement. For Medicare assignment and participating insurance plans, covered charges will be paid directly to us. We file to participating secondary payors one time only. If payment is not received within 45 days, we will send you a statement and payment will be expected at that time. This office cannot accept responsibility for negotiating a settlement on a disputed claim. If we do not participate in your insurance plan, you may still choose to be seen by the practice. We will require payment in full at the time services are rendered. As a courtesy to you, we will provide you with the documentation necessary for you to file with your insurance carrier on your own behalf.

Medicare Patients receiving Therapy Services: A \$1780 reimbursement cap is in effect for 2007 therapy claims filed with Medicare. There are exceptions provided for certain diagnoses, however. You may request assistance from our staff if you think you may be approaching your cap or you qualify for an exception. Once you have met the therapy cap for the year, you will be responsible for paying for the uncovered services.

*All* co-payments, co-insurance and deductibles are collected at time of service. In addition, required insurance referral forms must be complete, current and presented at time of service. If you arrive for your appointment without valid, current insurance identification or a required referral, we will offer you the option of rescheduling your visit or making payment in full at the time services are rendered. *All* patients are required to submit photo identification at the time of registration. We accept cash or checks, Visa, MasterCard, Discover or American Express. A fee of \$35.00 will be charged for checks returned for insufficient funds. An additional monthly fee will be charged on all past due accounts. Fees which are generally not covered by insurance plans will be charged for services such as copying of medical records and x-rays, completion of insurance/physical forms, issuance of handicapped parking stickers, etc. We require 24-hours notice if you wish to change or cancel your appointment. A \$35 charge may be assessed for appointments missed without this notice. We encourage you to contact us promptly for assistance in the management of your account. We are here to help you and will be happy to answer any questions you may have about your treatment or insurance coverage.

By signing below you are agreeing to the terms above and are providing OrthoBethesda consent to provide medical treatment.

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Signature of Patient, Policy Holder or Legal Guardian

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Date