

OrthoBethesda

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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	SOCIAL SECURITY NUMBER	CELL PHONE ()
OCCUPATION		PATIENT'S EMPLOYER / SCHOOL NAME AND ADDRESS			
EMERGENCY CONTACT NAME		RELATIONSHIP TO PATIENT	PHONE NUMBER ()		
If patient is under 18 years of age, please complete the following:					
ACCOMPANYING ADULT'S NAME		RELATIONSHIP TO PATIENT	SIGNATURE		
If patient is staying at a Skilled Nursing Facility, please complete the following:					
FACILITY NAME		FACILITY ADDRESS		FACILITY PHONE NUMBER ()	
PERSON FINANCIALLY RESPONSIBLE (if other than patient):					
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 ()	
CONDITION INFORMATION					
INJURED BODY PART		SIDE <input type="checkbox"/> Right <input type="checkbox"/> Left		DATE PROBLEM BEGAN OR OF THE MOST RECENT FLARE-UP	
PRIMARY CARE PHYSICIAN'S NAME		REFERRING PHYSICIAN , 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 HEALTH <input type="checkbox"/> PIP / AUTO <input type="checkbox"/> WORKERS COMP <input type="checkbox"/> SELF-PAY <input type="checkbox"/>					
PRIMARY INSURANCE					
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
SECONDARY INSURANCE <input type="checkbox"/> Medigap <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. 