THE ORTHOPAEDIC CENTER
A division of Centers for Advanced Orthopaedics

* S H A R E D I D – 4 2 *

Date of Birth:
Appointment Date:

Patient Registration

Account # _____ **Patient Name** **Social Security Number**	**Home Telephone #** _____ **Work Telephone #** _____ **Cell Telephone #** _____
Address	**Patient Sex**
City, State & Zip Code	**Date of Birth** _____ **Age** _____
FOR MEDICARE PATIENTS ONLY Do you currently reside in a Skilled Nursing Facility? ☐ Yes ☐ No	**Emergency Contact Name & Phone** **Relationship to Patient:**
Employment / Student Status: ☐ Full time employed ☐ Full time student ☐ Part time employed ☐ Part time student ☐ Unemployed ☐ Retired	**Employer Name & Address** **Occupation:**
Referring Physician: **Family Physician:** _____	**Email Address (please print)** **Married** ☐ **Single** ☐ **Other** ☐ **Spouse's Name**
Patient Smoking Status: ☐ **Current Everyday Smoker** ☐ **Heavy Tobacco Smoker** ☐ **Current Someday Smoker** ☐ **Light Tobacco Smoker** ☐ **Smoker, current status Unknown** ☐ **Never Smoker** **Start Date:** _____ ☐ **Former Smoker** **Quit Date:** _____ ☐ **Unknown if ever Smoker** **Packs per day:** _____ **Ethnicity of Patient:** ☐ **Hispanic Origin** ☐ **Non Hispanic Origin** ☐ **Unknown** ☐ **Declined to answer**	**Race of Patient:** ☐ **American Indian/ Alaskan Native** ☐ **Asian** ☐ **Black/ African American** ☐ **Native Hawaiian/ Other Pacific Islander** ☐ **White** ☐ **Unknown** ☐ **Declined to answer** **Preferred Language of Patient:** ☐ **English** ☐ **Spanish** ☐ **Other** _____
In compliance with the American Recovery and Reinvestment Act of 2009 (ARRA) to demonstrate Meaningful Use, we are required to capture demographic data including your preferred language, race and ethnicity.	
Financially Responsible Person (if different from above)	
Full Name **Address** **City, State & Zip Code** **Date of Birth** _____	**Social Security Number** _____ **Home Telephone #** _____ **Work Telephone #** _____ **Cell Telephone #** _____
Employer Name	**Relationship to the Patient (check one)** ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Other

*****All conversations between the patient and the physician may be recorded for the purposes of having an accurate transcript for the patient record.*****

Patient Registration

Insurance Company Information

Primary Insurance Company Name	**Secondary Insurance Company Name**
Address, City, State & Zip	**Address, City, State & Zip**
Policy Holder **Date of Birth**	**Policy Holder** **Date of Birth**
Policy Holder Employer **Policy Holder SSN**	**Policy Holder Employer** **Policy Holder SSN**
Policy Number **Group Number**	**Policy Number** **Group Number**
Relationship to the Patient (check one) ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Other	**Relationship to the Patient (check one)** ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Other

Appointment Information:

Patient Name: _____ **Account #:** _____

Name of physician to see today: _____

Name of physician who referred you here today: _____

Body area being seen for today: _____

Problem? ☐ **Yes** ☐ **No** **Date problem began** _____
Injury? ☐ **Yes** ☐ **No** **Date of Injury** _____
Work Injury ☐ **Yes** ☐ **No** **Date of Injury** _____
Auto Accident ☐ **Yes** ☐ **No** **Date of Accident** _____ **State of Accident** _____

Insurance Authorization and Assignment of Benefits

I certify that the information that I have reported with regards to my insurance coverage is correct. I also authorize the release of any medical information necessary to process this claim. I also authorize payment of medical benefits to The Orthopaedic Center, a division of The Centers for Advanced Orthopaedics, for anesthesia and orthopedic surgical services provided to me. I fully understand that payment for services is not contingent upon recovery and this does not relieve me of my primary obligation to pay.

Signature _____ Date _____

Medicare Patients

If you are covered by Medicare, please read and sign the following:
In Medicare cases, The Orthopaedic Center, a division of The Centers for Advanced Orthopaedics, agrees to accept the charge determination of Medicare as the full charge, and the patient is responsible only for deductible, coinsurance and non-covered services. Coinsurance and the deductibles are based upon the charge determination of Medicare.

Signature _____ Date _____

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SHAREDID-63

Date of Birth:

Appointment Date:

Patient Medical History

Name: _____ Date: _____

Age: _____ Date of Birth: _____ Height: _____ inches Weight: _____ lbs

CHIEF COMPLAINT

Why are you seeing the doctor today? _____

Have you ever been treated for this problem before? ☐ Yes ☐ No

Date of Injury/ Onset of problem _____

Current problem is a result of: *Check all that apply:*

Car Accident Work Accident Other *(specify)* _____

MEDICAL HISTORY

Are you currently receiving treatment or have you received treatment in the past for any of the following conditions?

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Anemia	☐	☐	Epilepsy	☐	☐	Kidney Problems	☐	☐	Pulmonary Embolism
☐	☐	Arthritis	☐	☐	Gallbladder Problems	☐	☐	Liver Disease	☐	☐	Rheumatic Fever
☐	☐	Asthma	☐	☐	Gout	☐	☐	Lung Problems	☐	☐	Sexually Transmitted
☐	☐	Birth Defects	☐	☐	Heart Disease	☐	☐	Phlebitis			Disease
☐	☐	Bladder Problems	☐	☐	Hepatitis	☐	☐	MRSA / Staph Infection	☐	☐	Stroke / TIA
☐	☐	Bleeding or Bruising	☐	☐	HIV / AIDS	☐	☐	Osteoporosis	☐	☐	Tuberculosis
☐	☐	Cancer Type _____	☐	☐	High Blood Pressure	☐	☐	Peripheral Vascular	☐	☐	Thyroid Problems
☐	☐	Diabetes	☐	☐	High Cholesterol	☐	☐	Disease	☐	☐	Ulcer Type _____
☐	☐	DVT / Blood Clots	☐	☐	Intestinal/ Bowel	☐	☐	Polio			
					Problems	☐	☐	Psychological problems			

Are there any other medical problems we should know about? _____

Are you right or left-hand dominant? ☐ Right ☐ Left Do you exercise or participate in sports regularly? ☐ Yes ☐ No

Are you or could you be pregnant? ☐ Yes ☐ No Type and Frequency: _____

Pharmacy Name: _____ Phone: _____ Location: _____

MEDICATIONS *Please list all medications you take with or without a prescription (use extra paper if needed)*

Medication Name	Dosage / # per day	Reason for taking

ALLERGIES *Please describe any current or past allergic reactions*

Allergy to (drug)	Reaction (itching, cough, hives, etc)	How was / is the reaction treated?

☐ I DO NOT have any allergies

SURGERIES AND HOSPITALIZATIONS

☐ Arthroscopy _____ Year _____ Physician _____ Complication? _____

☐ Joint replacement _____ Year _____ Physician _____ Complication? _____

☐ Bone or joint reconstruction _____ Year _____ Physician _____ Complication? _____

☐ Spine surgery _____ Year _____ Physician _____ Complication? _____

☐ Other general surgery _____ Year _____ Physician _____ Complication? _____

_____ Year _____ Physician _____ Complication? _____

☐ Other hospitalizations _____ Year _____ Physician _____ Complication? _____

☐ I HAVE NOT HAD any surgeries or hospitalizations

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* S H A R E D I D – 6 3 *

Date of Birth:

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FAMILY HISTORY

Have your mother, father, grandparents, brothers or sisters been treated in the past or are they currently receiving treatment for any of the following conditions?

Yes	No		Yes	No		Yes	No		
☐	☐	Alzheimer's	☐	☐	Diabetes	☐	☐	Osteoporosis	Other _____
☐	☐	Arthritis	☐	☐	Gout	☐	☐	Stroke	_____
☐	☐	Cancer	☐	☐	Heart Disease	☐	☐	Sudden Death	_____

SOCIAL HISTORY

Do you smoke or chew tobacco? ☐ Yes ☐ No Number: ____ packs per day for _____ years

Do you drink alcoholic beverages? ☐ Yes ☐ No Amount and frequency: _____

Do you use recreational drugs? ☐ Yes ☐ No Type and frequency: _____

REVIEW OF SYSTEMS

Please check the following symptoms you have experienced on a regular basis:

GENERAL
- ☐ Fever
- ☐ Weight change
- ☐ Hormonal problems
- ☐ Other _____
- ☐ NONE

CARDIOVASCULAR
- ☐ Chest pain
- ☐ Palpitations
- ☐ Fluid/ Swelling in extremities
- ☐ Other _____
- ☐ NONE

KIDNEY/ BLADDER
- ☐ Painful urination
- ☐ Frequent urination
- ☐ Incontinence
- ☐ Other _____
- ☐ NONE

EYES
- ☐ Glasses/ Contacts
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Other _____
- ☐ NONE

RESPIRATORY
- ☐ Shortness of breath
- ☐ Sleep apnea
- ☐ Wheezing
- ☐ Other _____
- ☐ NONE

EARS, NOSE, THROAT
- ☐ Difficulty swallowing
- ☐ Ear pain
- ☐ Seasonal allergies
- ☐ Hard of hearing
- ☐ Other _____
- ☐ NONE

GASTROINTESTINAL
- ☐ Heartburn
- ☐ Diarrhea/ Constipation
- ☐ Abdominal pain
- ☐ Nausea/ vomiting
- ☐ Other _____
- ☐ NONE

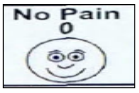
SKIN
- ☐ Rashes
- ☐ Lumps
- ☐ Other _____
- ☐ NONE

HEMATOLOGIC/ LYMPHATIC
- ☐ Anemia
- ☐ Blood problems
- ☐ Clotting disorder
- ☐ Lymph Problems
- ☐ Other _____
- ☐ NONE

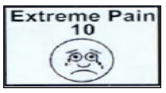
NEUROLOGICAL
- ☐ Headaches
- ☐ Numbness
- ☐ Tingling
- ☐ Seizures
- ☐ Weakness
- ☐ Other _____
- ☐ NONE

PSYCHOLOGICAL
- ☐ Anxiety
- ☐ Depression
- ☐ Mood swings
- ☐ Other _____
- ☐ NONE

Pain Scale - If you are having pain, please rate the intensity of your pain on a scale of 1 -10.



1 2 3 4 5 6 7 8 9



Patient Name: _____ **Date:** _____

Patient Signature: _____ **Date:** _____

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HIPAA AUTHORIZATION

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient's Name: _____ DOB: _____

Address: _____

I hereby authorize: **The Orthopaedic Center, A Division of CAO** to disclose my protected health information in accordance with this authorization.

I authorize my protected health information be disclosed to: *(for example a family member or other physician treating you)*

_____

Please indicate the information or types of information to be disclosed:

_____

_____

☐ This authorization includes my complete health record (including all dates of service)

☐ This authorization is only for dates of service from _____ to _____.

The purpose of this authorization is to facilitate complete treatment inclusive of all of my treating physicians.

This authorization may be revoked by me at any time except to the extent that the person(s) and/or organization(s) listed above have already acted in reliance upon this authorization. If I revoke this authorization, I need to do so in writing and mail or hand deliver it to:

The Othopaedic Center, 9420 Key West Avenue, Suite 300, Rockville, MD 20850

If not revoked by me, this authorization will terminate on: **January 1st, 2018**

I understand that I may inspect and/or copy the information to be disclosed.

I understand that this authorization is voluntary. I understand that I do not need to sign this form in order to ensure health care treatment, payment, enrollment in my health plan, or eligibility for benefits. I also understand that if I have any questions regarding the use or disclosure of my health information, I may contact the privacy officer at the health care provider authorized to disclose this information.

Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and will no longer be protected by the federal regulations protecting privacy of an individual's health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA Privacy Regulations") and other applicable federal and state law.

I understand that the information in my health record may include information or references to the existence of and/or treatment for **drug and/or alcohol abuse, mental health, (psychiatric records, psychological records, etc.) sexually transmitted diseases, tuberculosis, genetics, Hepatitis B or C, or human immunodeficiency virus (HIV) and/or acquired immune deficiency syndrome (AIDS).** This information will also be released unless I indicate by checking below that I do not want such information released:

DO NOT RELEASE _____

I DO NOT AUTHORIZE ANY PERSON TO ACCESS MY HEALTH RECORD. _____

Photocopies and facsimile copies of this Authorization shall be deemed to be originals.

_____ _____

Patient or Legal Representative Signature Date

_____ _____

Representative's authority to act on behalf of individual Witness

Date of Birth:
Appointment Date:
Patient Name:

Medical Assistant Notes:

Physician Notes

Height: **Height** inches

Weight: **Weight** lbs