Center for Orthopaedics and Sports Medicine

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PATIENT REGISTRATION

PATIENT INFORMATION (please print clearly)

First name:	Middle name:		Last name:
Date of birth:	Age:	Gender: ☐ M ☐ F	Social Security No.:
Parent/Guardian name (if patient under 18):			
Patient's address:		City:	State & zip code:
Home telephone:	Mobile telephone:		Email address:
Occupation:	Employer:		
Employer's address:		City:	State & zip code:

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Ethnicity:*	Race:*	Preferred language:*
☐ **Decline to state		Translator needed? ☐ Yes ☐ No

* Federal insurance programs and other insurances that receive federal funding require that we obtain this information. **If you do not wish to furnish this information.

How did you hear about us? ☐ Physician ☐ Friend/Family ☐ Google ☐ Insurance ☐ Employer ☐ ZocDoc ☐ Hospital/ER ☐ Other:

HEALTH INSURANCE INFORMATION

Primary Insurance Company Name:

Address:		City:	State & zip code:
Policy/ID #:	Group #:		Name of Policyholder:
Relationship to patient:	Date of birth:		Is this an HMO/PPO? ☐ Yes ☐ No

Secondary Insurance Company Name:

Address:		City:	State & zip code:
Policy/ID #:	Group #:		Name of Policyholder:
Relationship to patient:	Date of birth:		Is this an HMO/PPO? ☐ Yes ☐ No

PERSON FINANCIALLY RESPONSIBLE/INSURED (Complete only if patient is not the main policy holder)

First name:	Middle name:		Last name:
Relationship to patient:	Date of birth:		Social Security No.:
Home address:		City:	State & zip code:
Home telephone:	Mobile telephone:		Email address:

Name: Age: Gender: ☐ M ☐ F Appointment date:

AUTOMOBILE ACCIDENT

Date of accident: Time: ☐ am ☐ pm Were you: ☐ Driver ☐ Passenger

Do you have medical benefits under your auto ins.? ☐ Yes ☐ No If **YES**, Policy No./Claim#:

Your Automobile Insurance Carrier:

Address: City: State & zip code:

Telephone no.:

Your Agent's Name: Telephone no.:

Your claim adjuster's name: Telephone no.:

Other Party's Automobile Carrier:

Address: City: State & zip code:

Telephone no.:

Other Party's Claim Adjuster's Name:

Claim No.: Telephone no.:

COMPLETE IF AN ATTORNEY IS REPRESENTING YOU

Attorney's name: Telephone no.: Fax no.:

Address:

WORKERS' COMPENSATION (Injury on the Job)

Date of injury: Time: ☐ am ☐ pm Claim no.:

Compensation Insurance Co.: Address:

Insurance company: Contact person: Telephone no.:

Employer at time of injury: Telephone no.: Was injury reported to supervisor? ☐ Yes ☐ No

Date reported: Name of supervisor: Telephone no.:

Patient/Guardian signature Date:

For staff use only

☐ TYSONS CORNER ☐ FALLS CHURCH ☐ HERNDON OFFICE

Patient Chart Number:

PERSONAL DETAILS

Name: Age: Gender: ☐ M ☐ F Appointment date:

Emergency Information: who should we notify in case of emergency?

	Name	Relationship	Home Phone	Mobile Phone
Nearest relative/friend Living with you:				
Nearest relative/friend NOT living with you:				

Authorization

I, _____ hereby authorize CENTER FOR ORTHOPAEDICS AND SPORTS MEDICINE, INC. to apply for benefits on my behalf for covered services rendered by CENTER FOR ORTHOPAEDICS AND SPORTS MEDICINE, INC. I REQUEST THAT PAYMENT FOR THESE SERVICES BE PAID BY

_____

_____

Insurance Company #1 *S.S. # of Insured/ID* *Group*

_____

_____

Insurance Company #2 *S.S. # of Insured/ID* *Group*

Directly to Center for Orthopaedics and Sports Medicine, Inc. This is a direct assignment of my rights and benefits under the above-mentioned policy/ policies. I certify that the information I have provided above is correct. I further authorize Center for Orthopaedics and Sports Medicine, Inc. to release any necessary information, including medical information, for this or any related claim to the insurance companies named above, or in the case of medicare part b benefits, to the social security administration and health care financing administration. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing. I understand that I am responsible for the full settlement of my account regardless of insurance payments or reimbursements.

Witness signature Patient/Guardian signature Date

Financial Policies

For the benefit of our patients, our billing policies are described below.

1. Payment of the charges for our services is the ultimate responsibility of the patient. Payment is expected at the time services are rendered, except when alternative arrangements are made in advance with us.
2. Patients being scheduled for elective (planned) surgical procedures may be required to post a deposit amount before surgery which usually reflects the estimated part of the patient's responsibility for the procedure being planned. Any adjustments will be made following the patient's insurance company's payment of the procedure.

PLEASE NOTE: Patients being scheduled for physical therapy may require electrical stimulation. As a part of treatment, the use of electrodes may be necessary. These electrodes have contact with the patient's skin and for the patient's safety; patients will be required to purchase his/her own electrodes. The cost to the patient for these electrodes is a ONE-TIME fee of $17.50/pair. Should this treatment be deemed necessary, you agree to be responsible for this fee at the time of service.

Initial _____

Please be aware that insurance companies often do not fully cover a medical bill. This may result from deductible or co-payment provisions in the patient's policy, or because the insurance company has adopted a fee schedule, or for other reasons. However, an insurance company's failure to fully cover our bill does not relieve the patient of the obligation to pay our bill in full.

There will be a $35.00 Fee assessed to the patient for any physician appointment which is not cancelled 24 hours prior to the appointment time. Missed appointment fee is not covered by any insurance. It will be due from the patient.

Initial _____

If our bill is not paid in full when due, we encourage you to discuss with our billing staff alternative payment arrangements that may be acceptable to us. Generally, however, any bill not paid within 90 days will be referred for collection. Following 90 days delinquency, monthly interest charge of 1.4% Will accrue on the balance and all collection charges including attorney's fees of 20% on the unpaid balance and court costs will be added to the patient's account.

Please indicate that you have read and understood the foregoing billing policies by signing below.

Patient's/Responsible party's signature Patient's printed name Date

Witness signature Witness's printed name Date

COVID-19 PANDEMIC TREATMENT CONSENT FORM

Name: Age: Gender: ☐ M ☐ F Appointment date:

**** We are requesting all patients wear a mask at the time of their visit ****

We have numerous guidelines in place to minimize the risk of transmission. Nonetheless, it is still possible to contract COVID-19 while at a medical office.

1. I knowingly and willingly consent to have treatment completed during the COVID-19 pandemic. I understand that the COVID-19 virus has a long incubation period during which carriers of this virus may not show symptoms and may still be highly contagious.
2. I understand that due to the frequency of visits of other patients, the characteristics of the COVID-19 virus, and the characteristics of medical procedures, I have an elevated risk of contracting the COVID-19 virus simply by being in a medical office.
3. I confirm that I am not presenting any of these COVID-19 symptoms – fever, shortness of breath, dry cough, runny nose, sore throat.
4. I confirm that I have not been in contact with a person who has been diagnosed with COVID-19 within the past 14 days.
5. I understand that air travel significantly increases my risk of contracting and transmitting the COVID-19 virus, and that the CDC recommends social distancing of at least six feet for a period of 14 days to anyone who has recently traveled, and this is not possible with medical treatment.
6. I verify that I have not traveled outside the United States in the past 14 days.
7. I verify that I have not traveled domestically within the United States by commercial airline, bus or train within the past 14 days.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform the office of any changes in medical status.

Relationship to patient: ☐ Self ☐ Parent

Patient/Guardian signature Date:

PATIENT HEALTH HISTORY

Name: Age: Gender: ☐ M ☐ F Appointment date:

Height: Weight: Temp:

Name of primary care (family) physician: Consult requested by:

Preferred pharmacy (name and address):

CURRENT MEDICATIONS

Are you currently taking any blood thinners? ☐ Yes ☐ No

What medications are you currently taking?

Name:	Dosage:	Frequency:
Name:	Dosage:	Frequency:
Name:	Dosage:	Frequency:

* If you have additional medications, please list on a separate sheet.

PAST HEALTH HISTORY

Anxiety	☐ Yes	☐ No	Depression	☐ Yes	☐ No	Major infection	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Elevated cholesterol	☐ Yes	☐ No	Stomach ulcer	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Fractures	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
AIDS / HIV	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Sleep apnea	☐ Yes	☐ No
Blood clots/DVT	☐ Yes	☐ No	Heart attack	☐ Yes	☐ No		☐ CPAP	
Cancer	☐ Yes	☐ No	Heart disease	☐ Yes	☐ No	Thyroid disease	☐ Yes	☐ No
Type:			Hypertension	☐ Yes	☐ No	Type:	☐ High	☐ Low
Diabetes	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Other	☐ Yes	☐ No
Type:	☐ I	☐ II	Type:	☐ A	☐ B ☐ C	If YES, list:		

FAMILY HISTORY

Father – Alive?	☐ Yes	☐ No	Age deceased:		Health Status:	☐ Good	☐ Fair	☐ Poor	
Mother – Alive?	☐ Yes	☐ No	Age deceased:		Health Status:	☐ Good	☐ Fair	☐ Poor	
Heart Disease	☐ Father	☐ Mother	☐ Brother	☐ Sister					
Hypertension	☐ Father	☐ Mother	☐ Brother	☐ Sister					
Asthma	☐ Father	☐ Mother	☐ Brother	☐ Sister					
COPD	☐ Father	☐ Mother	☐ Brother	☐ Sister					
Arthritis	☐ Father	☐ Mother	☐ Brother	☐ Sister					
Osteoporosis	☐ Father	☐ Mother	☐ Brother	☐ Sister					
Stroke	☐ Father	☐ Mother	☐ Brother	☐ Sister					
Diabetes before age 18	☐ Father	☐ Mother	☐ Brother	☐ Sister					
Diabetes after age 18	☐ Father	☐ Mother	☐ Brother	☐ Sister					
Bleeding problems	☐ Father	☐ Mother	☐ Brother	☐ Sister					

SURGERIES AND HOSPITALIZATIONS

Have had problems with anesthesia (being numbed or put to sleep)? ☐ Yes ☐ No If **YES**, please list what type of problems:

Have you ever had surgery before? ☐ Yes ☐ No If **YES**, please list all surgeries:

SOCIAL HISTORY

Do you currently smoke?	☐ Yes ☐ No	# packs/day			
Have you ever smoked?	☐ Yes ☐ No	# of years	# packs/day		
Alcohol use:	☐ None	☐ Socially	☐ Rarely	☐ Moderately	☐ Heavily
Drug use:	☐ None	Type/Frequency:			
Exposure at home or work to:	☐ None	☐ Smoke	☐ Fumes	☐ Other:	
Do you exercise?	☐ Yes ☐ No	How often # times/week:			
Type of exercise:					

ALLERGIES

Are you allergic to any of the following:	☐ Adhesive tape	☐ Antibiotics	☐ Latex	☐ Barbiturates (Sleeping pills)	☐ Aspirin
	☐ Iodine	☐ Codeine	☐ Sulfa	☐ Local anaesthetics	
Do you have any other allergies?	Name:			Reaction:	
☐ No known drug allergies (NKDA)	Name:			Reaction:	

REVIEW OF SYSTEMS

Problems you have or have had recently in the following areas (check all symptoms that apply):

General/Constitutional	☐ None	☐ Weight gain	☐ Weight loss	☐ Fever and chills	☐ Fever	
Eyes	☐ None	☐ Eye pain	☐ Red eyes			
ENT	☐ None	☐ Dizziness	☐ Hearing loss	☐ Ear pain	☐ Nosebleeds	☐ Sore throat
Heart and Blood vessels	☐ None	☐ Chest pain	☐ Irregular heart beat	☐ Swelling		
Lungs and Respiratory system	☐ None	☐ Non-productive cough	☐ Productive cough	☐ Coughing up blood		
Stomach and Digestive system	☐ None	☐ Abdominal pain	☐ Frequent nausea	☐ Frequent vomiting		
Bones, Joints or Muscles	☐ None	☐ Cramping	☐ Pain in back	☐ Painful joints	☐ Stiffness	☐ Weakness
Neurologic	☐ None	☐ Frequent headache	☐ Face pain	☐ Seizures	☐ Loss of consciousness	
		☐ Tingling	☐ Fatigue			
Mental and Emotional health	☐ None	☐ Trouble sleeping	☐ Anxiety	☐ Depression		
Endocrine	☐ None	☐ Increased appetite	☐ Increased fatigue	☐ Increased thirst		
		☐ Enlarged neck	☐ Pain in neck			
Allergies, Infections, Immune system	☐ None	☐ Frequent infections	☐ Severe reaction to insect bite			

Patient/Guardian signature Date:

MEDICAL HISTORY FORM: LOWER EXTREMITY

Name: Age: Gender: ☐ M ☐ F Appointment date:

REASON FOR VISIT

What is the reason for your visit today? (Please include all relevant details)

Location: ☐ Right ☐ Left ☐ Bilateral (Both Left & Right)

Do you use any of the following assistive devise to walk? (Check all that apply) ☐ No assistive device ☐ Cane ☐ Crutches ☐ Walker ☐ Wheelchair

Context: Is this the result of an injury? If so, what date did it occur? ☐ Yes ☐ No

If **YES**, what type of injury?
☐ Sports injury: What sport?
☐ Car accident (MVA)
☐ Other:

Work related: Did this injury occur while working? If so, what date did it occur? ☐ Yes ☐ No

Duration: How long have you had this problem?

Onset: How quickly did the pain start?
☐ Suddenly (Immediate onset, as in on injury)
☐ Gradual (slowly, overtime)

Status: How has the pain changed? ☐ Improving ☐ Resolved ☐ Stable ☐ Worse

Frequency: How often is the pain present? ☐ Intermittent (comes and goes) ☐ Constant ☐ Rare

Intensity: On a scale of 1-10 (10 being the most painful), how severe is the pain? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Quality: How would you describe the pain? ☐ Aching ☐ Burning ☐ Dull ☐ Sharp ☐ Throbbing

Aggravated by (what makes the pain worse?)
☐ Nothing ☐ Standing ☐ Walking ☐ Climbing stairs
☐ Descending stairs ☐ Sitting ☐ Activity ☐ Work
☐ Other:

Relieved by (what makes the pain better?)
☐ Nothing ☐ Brace/splint ☐ Elevation ☐ Exercise
☐ Ice ☐ Injections ☐ Massage ☐ Physical Therapy
☐ Stretching ☐ Rest ☐ Other:

Do you have any of the following associated symptoms?

Decreased mobility (stiffness)	☐ Yes ☐ No	Numbness	☐ Yes ☐ No
Instability (giving away)	☐ Yes ☐ No	Popping (something clicking)	☐ Yes ☐ No
Locking (stick in position)	☐ Yes ☐ No	Swelling	☐ Yes ☐ No
Night pain	☐ Yes ☐ No	Weakness	☐ Yes ☐ No

Have you used any medication for this problem?

Anti-inflammatory medications - Please list *(e.g. Ibuprofen, Advil, Aleve)*:

Pain (prescription) medications - Please list:

Does the medication relieve your pain? ☐ Yes ☐ No ☐ Temporarily/Partially

Imaging: Have you had any of the following? ☐ X-rays ☐ MRI ☐ CAT scan ☐ Doppler U/S ☐ EMG/NCV ☐ Bone Density ☐ Other:

Additional History
Please list any other details about your pain or injury that have not been covered above

Have you had any previous surgery for this condition? ☐ Yes ☐ No

If **YES**, please list the date(s) and type of evaluations and/or treatments.

Unsuccessful treatments:
What previous treatments have you tried that have been unsuccessful?

☐ Nothing ☐ Brace/splint ☐ Exercise ☐ Heat
☐ Ice ☐ Massage ☐ Rest ☐ Physical Therapy

History: In the past have you ever had another problem to this same part of your body? ☐ Yes ☐ No

If **YES**, please list the date(s), type of evaluations and/or treatments and whether or not your symptoms were resolved.