Maryland Orthopedic Institute

Christopher M. Farrell, MD
Board Certified Orthopedic Surgeon
Joint Replacement & Sports Medicine

To Our Patients:

Welcome to Maryland Orthopedic Institute. We look forward to meeting you at your first visit. We are dedicated to providing the highest quality orthopedic care while offering a comforting patient experience. Our goal is to work with you and your other healthcare providers to help you regain your function and improve your quality of life.

In order to accomplish these goals, and facilitate your initial visit, please review and complete the following forms.

***Patient Registration**
***Medical Questionnaire**

Please plan to bring them to your first visit.

On the day of your visit, please arrive early and bring your insurance card, photo identification, referral if required and the completed forms.

If your orthopedic problem has been previously evaluated, it would be helpful to bring office notes, operative reports, prior x-rays, CT scans or MRI images to your visit with Dr. Farrell.

Thank you for choosing Maryland Orthopedic Institute. We are committed to the care of you and your family.

Sincerely,

Christopher Farrell, M.D. and staff
Maryland Orthopedic Institute

Phone: 240 449 8262 Fax: 240 449 8257 www.md-ortho.com 6420 Rockledge Drive, Suite 4290, Bethesda, MD 20817

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PATIENT REGISTRATION

PLEASE FILL IN ALL OF THE FOLLOWING CONFIDENTIAL INFORMATION
This information is required by insurance companies.

Patient's Name:_____Date of Birth:_____
Occupation:_____Age:_____
Gender:_____Marital Status:_____

Address:_____City:_____Zip:_____
Email address:_____
Phone: Home:_____Work:_____Cell:_____ *please star preferred #
Parent's Name (If Child):_____

Patient's Social Security#_____Driver's License#_____
Name of Person Responsible for Bill:_____
(If Other than Self)
Address:_____
Relationship:_____Phone:_____

Patient's Employer:_____
(Or Parent's Employer ,if minor)
Address:_____Phone:_____
Spouse's Employer:_____Spouse's DOB:_____Spouse's Name:_____
Address:_____
Name of Person to Notify in Emergency:_____Phone:_____

Is this a Worker's Compensation Claim: Yes_____ No_____
Adjuster Name:_____ Adjuster's Phone:_____
Insurance Carrier_____Claim#_____
Address:_____
Insurance Carrier Phone:_____
Health Insurance Company Name:_____Phone #:_____
Policy#_____Group#_____
Insured Name:_____DOB:_____
Secondary Insurance Name:_____Phone #:_____
Policy #:_____Group #:_____
Insured name:_____DOB_____

I certify that the above information is correct and true. I authorize release of any necessary information, including medical information for this or any related claim to my insurance company.

X_____
Signature of patient, policyholder or legal guardian Date
Name:_____ Date:_____ DOB:_____

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MEDICAL QUESTIONNAIRE

What is the reason for today's visit?_____
Location of symptoms:_____
Date symptoms started:_____
How symptoms/injury occurred:_____
Severity of symptoms (scale 1-10,10 being worse):_____
What had made symptoms better or worse:_____

Have you seen other physicians for this problem?_____
List medical problems (ex: asthma, diabetes, blood pressure, blood clots)_____
List previous surgeries:_____
Family History(blood clots, cancer, rheumatism):_____
Social History:(smoke, drink, drug use)_____
List current medications (prescription and over the counter): _____
_____
Allergies to Medications:_____
Do you Smoke?_____Drink Alcohol?_____Exercise regularly?_____

Review of Symptoms: (*check any that are abnormal and explain*)
( )General (fever/night sweats, chills, weight loss)_____
( )Eyes, ear,nose,throat (runny nose, sore throat)_____
( )Heart (chest pain, palpitations)_____
( )Respiratory (difficulty breathing, recent cough, PE)_____
( )Gastrointestinal (ulcers, stomach aches)_____
( )Skin (rash)_____
( )Psychiatric (depression, anxiety)_____
( )Endocrinologic (thyroid disease)_____
( )Hematologic(blood clots, stroke, bleeding)_____
( )Genitourinary (incontinence, kidney stones)_____
( )Musculosketal/Rheumatologic (bones/joints)_____

Height_____(ft)_____(in) Weight_____(lbs)
Any Possibility of being Pregnant?_____
Name of primary physician:_____ Phone:_____
Address:_____
How did you find out about Maryland Orthopedic Institute?_____
What sports do you currently participate in?_____
How many days/week do you participate?_____

Physician's Signature:_____
Please note: If prescribed a therapy program, it may include strenuous exercise. If you have concerns please check with your regular physician before starting the exercise program.

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ACKNOWLEGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ _____
Signature of Patient or Personal Representative Date

_____
Print Name of Patient or Personal Representative
(If using a Personal Representative: Description of their Authority_____)

GENERAL RELEASE OF INFORMATION

I hereby authorize Maryland Orthopedic Institute i.e. M.O.I. To release information regarding my care to my insurance company and to other physicians involved in my case. I hereby give permission to the physician and staff of Maryland Orthopedic Institute i.e. M.O.I. to examine and treat my medical condition.

_____ _____
Signature of Patient Date (Parent if Patient is a Minor)

FINANCIAL RESPONSIBILITY AGREEMENT

Please be advised that it is the policy of this office to estimate and collect patient responsibility amounts at the time of your visit. This amount includes co-payments, deductibles, coinsurance and any items not covered by your insurance plan. Payment will be expected at the time of service unless prior arrangements have been made. Failure to do so may results in the rescheduling of your appointment.

I understand that not all services offered by my physician are covered by my insurance plan. I agree to be directly responsible for payment of charges, co payments, deductibles, and any other services that are not covered by my insurance plan. (Example: Heel pads, braces, sling, waterproof cast liners and other Durable Medical Equipment (DME).

I FULLY UNDERSTAND AND AGREE TO THE ABOVE POLICIES AND AUTHORIZATIONS

Patient/Guardian_____ Date_____

OTHER INSURANCE INFORMATION

I certify by my signature below, that I DO/ DO NOT have any other secondary health insurance coverage. If you do have secondary coverage, please provide the name below.

Secondary Insurance Name:_____

Please allow the receptionist to make a copy of your card

Signature of Patient/Guardian_____ Date_____

FOR WORKERS COMPENSATION PATIENTS ONLY

This is to authorize Maryland Orthopedic Institute to release any information regarding my care to my employer's insurance carrier. Also, I authorize payment of medical benefits to Maryland Orthopedic Institute i.e. M.O.I.

Signature of Patient_____Date_____