Northern
Virginia
**Orthopaedic**
Specialists

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**Kevin E. Peltier, M.D.**
**John J. Kim, M.D.**
**Keith S. Albertson, M.D.**

We would like to thank you for selecting Northern Virginia Orthopaedic Specialists for your orthopaedic care. NVOS is the oldest orthopaedic group practice in western Prince William County and has been serving the area since 1995. All of our surgeons are board-certified specialists who provide care that is consistently recognized for quality and cost-effectiveness.

Attached is our registration packet. We would also like to thank you for downloading this paperwork so that we may begin to process your information prior to your appointment. Providing this information prior to your appointment allows our practice to save time which in turn increases the quality of the service we provide and decreases the cost of providing world-class care.

Please submit this paperwork to us prior to your appointment by fax to **703-369-9240**. We are in the process of upgrading our systems to accept registrations online and appreciate your understanding while we improve our business processes.

# REGISTRATION FORM
**(Please Print)**

| Today's Date: | Primary Care Physician: |
|---|---|

**PATIENT INFORMATION**

| Patients Last Name: | First: | M.I.: | Birth Date: / / | Age: | Sex: ☐ M ☐ F |
|---|---|---|---|---|---|
| Street Address (required even if you have a PO Box): | SSN: | Home Phone No.: ( ) | Mobile Phone No.: ( ) | | |
| P.O. Box: | City: | State: | Zip Code: | | |
| Employer: | Occupation: | Work Phone No.: ( ) | | | |

**Patient's Spouse(if any)**

| Name: | SSN: | Birth Date: / / |
|---|---|---|
| Employer: | Occupation: | Work Phone No.: ( ) |

**FOR MINOR PATIENTS OR PATIENTS UNDER PARENT'S INSURANCE POLICY**

**Patient's Mother**

| Mother Name: | Street Address: | City: | |
|---|---|---|---|
| State/ Zip Code: | Phone No.: ( ) | SSN: | Birth Date: / / |
| Employer: | Occupation: | Work Phone No.: ( ) | |

**Patient's Father:**

| Father's Name: | Street Address: | City: | |
|---|---|---|---|
| State/ Zip Code: | Phone No.: ( ) | SSN: | Birth Date: / / |
| Employer: | Occupation: | Work Phone No.: ( ) | |

**Insurance Information *REQUIRED***

| Primary Insurance: | Subscribers Name***REQUIRED***: | Subscribers Date of Birth***REQUIRED***: |
|---|---|---|
| Secondary Insurance: | Subscribers Name***REQUIRED***: | Subscribers Date of Birth***REQUIRED***: |

**IN CASE OF EMERGENCY**

| Name of local friend or relative: | Relationship to patient: | Phone No.: ( ) |
|---|---|---|

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. In the event this account must be placed with an attorney or collections agency, I agree to pay all collection, attorney, or interest fees. I also authorize Northern Virginia Orthopaedic Specialist or insurance company to release any information required to process my claims.

| Patient/ Guardian Signature: | Date: |
|---|---|

We are happy to assist you with your insurance claims, however it is our policy that benefits for payment must be assigned to our office before your care here is initiated.

**Assignment**

I hereby request and authorize my insurance company(s) to pay direct to Northern Virginia Orthopaedic Specialists for any surgical and/or medical benefits, otherwise payable to me for services rendered.

I further agree to pay any and all amounts that are not paid by any insurance carriers promptly when billed. I understand payment is due when services are rendered and I agree to pay the same promptly. If my account is forwarded for collections due to non-payment, I will be responsible for all collection, attorney, and interest fees.

I certify that the information I have reported with regard to my insurance coverage is correct. Additionally, I have received a copy of NVOS's practice policies and fees.

____________________________________________ ____________________

Patient/Guardian Signature Date

**Important Notice Regarding Patient Information**

I understand that all health information gathered by Northern Virginia Orthopaedic Specialists as a result of my examination and treatment will be handled according to Northern Virginia Orthopaedic Specialists Privacy Policy. I have received a paper copy of this policy. Furthermore, I understand that this policy may be updated from time to time and I may request a current copy for as long as Northern Virginia Orthopaedic Specialists maintains a record of my health information.

Please note, many insurance companies require us to submit health information in order to receive payment. Accordingly we must share your health information when requested by your insurance company.

____________________________________________ ____________________

Patient/Guardian Signature Date

**Prescription Monitoring Program for Controlled Substances**

I understand that Northern Virginia Orthopaedic Specialists participates in the Virginia Prescription Monitoring Program. I give permission for my physician to access this database if needed, in the event he prescribes me a controlled substance. Further, I understand and agree that my physician may consult with any other physician prescribing controlled substances to me for prescription compliance.

____________________________________________ ____________________

Patient/Guardian Signature Date

# Comprehensive Patient History Form

Patient Name:________________________________ Date:______________

Describe the reason for your visit today (body part)_______________________________________________

How long have you had this problem?________________________________________

When did this problem start (Date)? ________________________________________

(Approximate Time)________________________________________

Where is your problem located? (Circle One)

Right Left Both N/A

Was there an injury? YES NO

If this is an injury:

How did it occur?__________________________________________________

Did it occur at work? yes no

Was this a motor vehicle accident? yes no If yes, in what state did the motor vehicle accident occur?_____

Was this a sports injury? yes no

Are you working with an attorney yes no

Please describe your symptoms______________________________________________________________

Does anything you do aggravate this? ________________________________________________________

Is it relieved by anything? __________________________________________________________________

Any other associated symptoms? ____________________________________________________________

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**Symptoms** Check (✓) symptoms you current have or have had in the past year.

**Constitutional**
- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Malaise
- ☐ Night sweats
- ☐ Weakness
- ☐ Weight gain
- ☐ Weight loss

**Metabolic/Endocrine**
- ☐ Cold intolerance
- ☐ Hair loss
- ☐ Heat intolerant

**Gastrointestinal**
- ☐ Abdominal pain
- ☐ Constipation
- ☐ Black tarry stool
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Jaundice
- ☐ Loss of appetite
- ☐ Nausea
- ☐ Vomiting

**Cardiovascular**
- ☐ Chest pain
- ☐ Cyanosis
- ☐ Heart murmur
- ☐ Irregular heartbeat/ palpations
- ☐ Leg swelling
- ☐ syncope

**Head, Ears, Nose, Throat**
- ☐ Blurred vision
- ☐ Double vision
- ☐ Painful swallowing
- ☐ Ear drainage
- ☐ Facial pain
- ☐ Headache
- ☐ Hearing loss
- ☐ Hoarseness
- ☐ Nasal congestion
- ☐ Ringing in ears
- ☐ Vertigo
- ☐ Vision loss
- ☐ Dizziness
- ☐ Poor coordination

**Skin**
- ☐ Contact allergy
- ☐ Itchy skin
- ☐ Rash
- ☐ Skin infections
- ☐ Skin lesion

**Neurological**
- ☐ Difficulty walking
- ☐ Muscle weakness
- ☐ Numbness
- ☐ Seizures
- ☐ Tremors
- ☐ Memory loss

**Psychiatric**
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia

**Immune System**
- ☐ Asthma
- ☐ Contact dermatitis
- ☐ Food allergies
- ☐ Bee sting allergy
- ☐ Environmental allergies
- ☐ Seasonal allergies

**Musculoskeletal**
- ☐ Clicking joints
- ☐ Decreased mobility
- ☐ Joint pain
- ☐ Joint swellling
- ☐ Limping
- ☐ Popping Joint

**Genitourinary**
- ☐ Urge incontinence
- ☐ Blood in urine (hematuria)
- ☐ Painful urination (dysuria)
- ☐ Frequent urination
- ☐ Urinary incontinence

**Respiratory**
- ☐ Chest pain
- ☐ Cough
- ☐ Dyspnea
- ☐ Recent infections
- ☐ Known TB exposure
- ☐ Wheezing

Patient Name:______________________________________ Date:___________

## History

**Patient Medical/Surgical History**
List any previous surgery and year (list most recent first)

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

**Have you ever had the following?**

| | | |
|---|---|---|
| Diabetes/sugar............ | yes | no |
| Hypertension/ High Blood Pres.... | yes | no |
| Cancer.................... | yes | no |
| Stroke..................... | yes | no |
| Heart disease.............. | yes | no |
| Arthritis/gout............ | yes | no |
| Seizures.................. | yes | no |
| Bleeding tendency........ | yes | no |
| Asthma.................... | yes | no |
| COPD...................... | yes | no |
| Sleep apnea.............. | yes | no |
| HIV........................ | yes | no |
| Hepatitis.................. | yes | no |

**Family Medical History**

| | Age | Diseases | Cause of Death &Year |
|---|---|---|---|
| Father | ______ | ____________________ | ____________________ |
| Mother | ______ | ____________________ | ____________________ |
| ❑ Brother ❑ Sister | ______ | ____________________ | ____________________ |
| ❑ Brother ❑ Sister | ______ | ____________________ | ____________________ |
| ❑ Brother ❑ Sister | ______ | ____________________ | ____________________ |

**Patient Social History**

What is your occupation?____________________________________________

Hand Dominance: ❑ Right ❑ Left ❑ Ambidextrous

Activity Level: ❑ Moderate ❑ Sedentary ❑ Vigorous What Type:_______________ Exercise frequency:_____________________

Use of alcohol: ❑ Never ❑ Previous, but quit _________________(how long ago?) ❑ Drinks per day/week___________________

Is there a family history of alcohol or drug abuse? ❑ No ❑ Yes

Have you ever been treated for drug or alcohol abuse? ❑ No ❑ Yes If yes, please indicated ❑ Alcohol ❑ Drugs

Have you ever been in pain management? ❑ No ❑ Yes

Use of tobacco: ❑ Never ❑ Previous, but quit ___________ (how long ago?)

❑ Current packs per day _________ and number of years a smoker ______

Use of caffeine: ❑ No ❑ Yes If yes, how much?_________________

| PLEASE LIST ALL CURRENT MEDICATIONS | | PLEASE LIST ALL KNOWN ALLERGIES | |
|---|---|---|---|
| **Medication:** | **Dosage:** | **Allergy:** | **Reaction:** |
| ____________ | ____________ | ____________ | ____________ |
| ____________ | ____________ | ____________ | ____________ |
| ____________ | ____________ | ____________ | ____________ |
| ____________ | ____________ | ____________ | ____________ |
| ____________ | ____________ | ____________ | ____________ |
| ____________ | ____________ | ____________ | ____________ |
| ____________ | ____________ | ____________ | ____________ |

Patient Name:________________________________ Date:____________

| Severity of Pain | Frequency - the pain is: |
|---|---|
| □ Mild □Moderate □Severe □Incapacitating | □Intermittent □Occasional □Rare □Constant |

| Does the pain radiate? | Is the pain: |
|---|---|
| □Yes □No | □Changing □Improving □Fluctuating □Resolved □Stable □Worse |

If yes – to where does the pain radiate:

**Instructions:**

- On the body diagram below, please indicate where your pain is located **at the present time**, using the symbols below to show the particular types of pain. Please do not indicate areas of pain that are not related to your present injury or condition.

**Pins & Needles**

0 0 0 0 0 0 0

**Numbness**

= = = = =

**Burning**

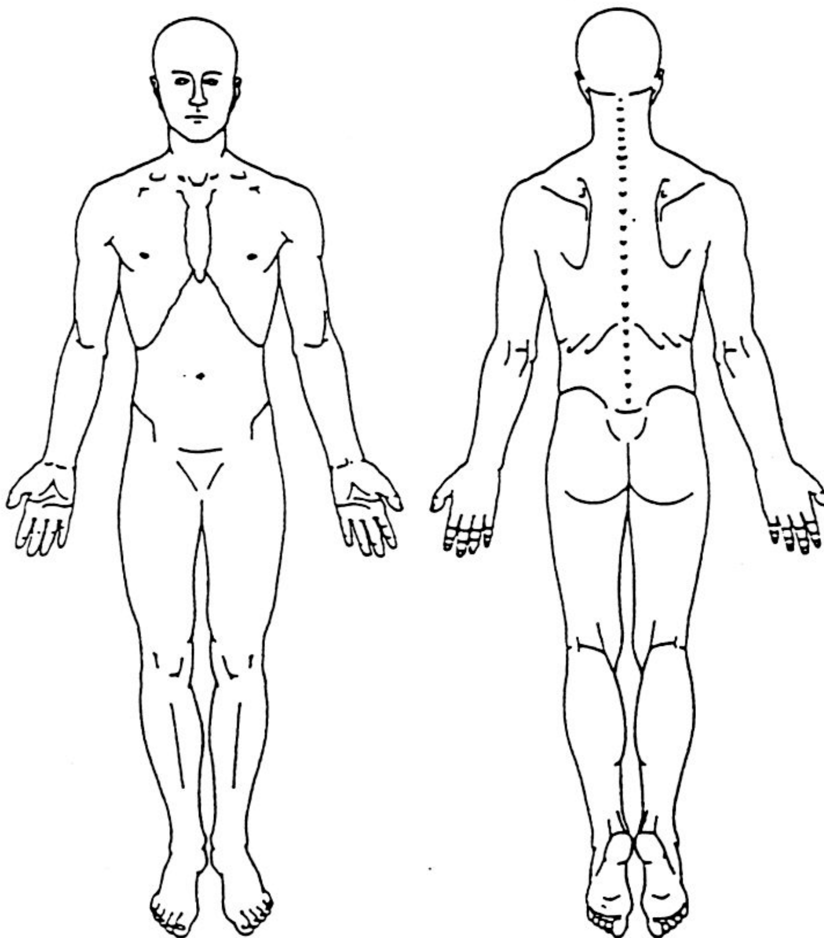
X X XX X X

**Stabbing**

/ / / / / / / / /

**Ache**

**Λ Λ Λ Λ Λ Λ**



Patient Signature____________________________________ Date____________

Physician Signature__________________________________ Date____________

8644 Sudley Road, Suite 308
Manassas, VA 20110

703.369.9070 Phone
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www.nvos.com

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# EFFECTIVE: MARCH 7, 2016
# Fees

**Medical Records:**

| | |
|---|---|
| First 50 pages | $0.50 per page |
| Thereafter | $0.25 per page |
| Search & Processing | $10 |
| Shipping Charges | Cost to ship records |

*Process time may take up to 2 weeks.

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**Forms:**

$15 per form (1-2 pages) $25 per form (3 or more pages)

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**X-ray CD:**

$5 per CD Paid in advance

*Paper copies are free.

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**Bounce or Stopped Check:**

$50 per check

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**Missed Appointment:**

$50 per appointment

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**Patient Cancelled Surgery:**

$300 per surgery

* If you cancel your surgery within a week of your scheduled surgery date, you will be charged a cancellation fee.
* If a physician has not medically cleared you for surgery, there is no fee.

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# Practice Policies

**Copays:**

- If your insurance policy has a copay, the copay must be paid before each visit or your appointment will have to be rescheduled.

**Referrals:**

- If your insurance policy requires a referral, you must bring that referral with you to your visit.
- If you have a new injury, you will need a new referral.
- You must also keep track of the number of visits used for each referral. If you are unsure of the number of visits left on your referral, you may call our office 3 business days before your next appointment. If a new referral is needed, this will allow you enough time to contact your primary care physician and for them to process the referral, which may take several days.
- If you do not have your referral for your visit, you will have to be rescheduled.

**Surgery:**

- If you are scheduled for surgery, please note that the process requires that we coordinate the doctor's schedule with availability at the hospital or surgery center, as well as getting approval for the surgery from your insurance company. It is our goal to expedite this process, but note that it can be a lengthy process.
- Depending on your insurance, you may be required to pay a copay, portion of your deductible, or a down payment.
- If you cancel your surgery within a week of your scheduled surgery date, you will be charged a cancellation fee. If a physician has not medically cleared you for surgery, you will not be charged a cancellation fee.

**MRIs:**

- Please note that many insurance companies require authorizations for MRIs. Additionally, some of these companies require office notes from the physician or they may have to be reviewed by an insurance company nurse or physician. In any event, we will work hard to get these tests approved as quickly as possible, but in some cases this may take several days.
- When have scheduled your MRI, call our office so that we can schedule a follow-up appointment for your doctor to review those results with you. Unfortunately, this cannot be done over the phone, you must come in for a follow-up visit.
- If you have your MRI done at a facility other than Prince William Hospital, you must bring the actual films or CD, along with the radiologists report, to your visit.