The Centers
for Advanced Orthopaedics
Maryland Orthopedic Institute

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

To Our Patients:

Welcome to Maryland Orthopedic Institute, *A Division of Centers For Advanced Orthopaedics*. 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
A Division of Centers for Advanced Orthopaedics

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

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*PLEASE FILL IN **ALL** OF THE FOLLOWING CONFIDENTIAL INFORMATION*

Patient's Last, First, MI Date of Birth Age Gender

Name _____ _____ ____ _____ _____ ☐M ☐F

Street Address_____City & State_____ Zip Code _____ Marital status: ____

Home Phone _____ Cell Phone: _____ Email address: _____

Social Security _____ Occupation: _____ Patient's Employer_____

Business Phone: _____ Employer's Address: _____

City & State: _____ Zip Code_____ Guarantor's Name (Parent-Spouse, etc._____

Emergency Contact Name: _____ Phone # _____ Relationship to Patient: _____

Street Address: _____ City, State _____ Zip Code_____

INSURANCE INFORMATION

Name of **Primary** Insurance Co._____ Policy/ID/No._____

Group No._____ Claim Address: _____

Policy Holder's/Subscriber's Name: _____ Subscriber's Date of Birth_____

Subscriber's SS# _____ Relationship to Patient_____ Subscriber's Employer: _____

Name of **Secondary** Insurance Co.:_____ Policy/ID: _____

Group No.:_____ Claim Address: _____

Policy Holder's/Subscriber's Name: _____ Subscriber's Date of Birth_____

Subscriber's SS# _____ Relationship to Patient_____

INJURY - AUTOMOBILE ACCIDENT

Your Auto Insurance Co _____ Your Claim No._____

Adjuster_____ _Adjuster's Phone _____ Are you the □ Driver □ Passenger □ Pedestrian?

Name of Policy Holder: _____ Phone #: _____

INJURY - WORKER'S COMPENSATION

Worker's Comp. Insurance Co.:_____ Claim no._____

Adjuster: _____ Adjuster's Phone#: _____

Claim Address: _____

Employer at time of Injury_____ Phone#: _____

Was injury reported to Supervisor? Yes □ No □ Name of Supervisor: _____

Signature of patient, policyholder or legal guardian: _____ Today's Date: _____

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MEDICAL QUESTIONAIRE

Name: _____ **Date:** _____ **DOB:** _____

About your Illness/Injury

What are you being seen for today or what hurts? _____

Location of symptoms: _____

Date symptoms started: _____ Severity of symptoms (scale of 1-10, 10 being worse) _____

Describe how your injury occurred and your symptoms? _____

What makes the symptoms better or worse? _____

I have previously or am being treated by a physician for the following conditions: (please check)

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, Exercise) _____

List current medications (prescription and over the counter): _____

Allergies to Medications: _____

Do you Smoke? __ Yes __ No **Do you Drink Alcohol? __Yes __No** **Do you Exercise Regularly? __Yes __ No**

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) _____
( ) Musculoskeletal /Rheumatologic (bones/joints) _____

Do you /Have you suffered from tick bites or Lyme disease (circle): Yes / No

Other problems that I have (more info) _____

Personal Information

Height: ____ Weight: ____ Referring Physician or Attorney _____

Primary Care Physician: _____ Address: _____

Are you currently residing in a nursing home or hospice ☐Yes ☐ No **Preferred Pharmacy Location:** _____

How did you find us? ☐Referring Physician: ☐Another Patient: ☐Other: _____

What sports do you currently participate in? _____

Physician Signature: _____ **Date:** _____

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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.), *A Division of the Centers for Advanced Orthopaedics* o 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.), *A Division of the Centers for Advanced Orthopaedics* to examine and treat my medical condition.

_____ _____
Signature of Patient (*parent if patient is a minor*) Date

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 understand that if I miss my appointment without 24-48 hours notification I may be charged a $50.00 missed appointment fee.

I FULLY UNDERSTAND AND AGREE TO THE ABOVE POLICIES AND AUTHORIZATIONS

_____ _____
Signature of Patient/Guardian Date

OTHER INSURANCE INFORMATION

I certify by my signature below, that **I DO/ DO NOT** (***circle one***) 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, *A Division of the Centers for Advanced Orthopaedics* to release any information regarding my care to my employer's insurance carrier. Also, I authorize payment of medical benefits to Maryland Orthopedic Institute (M.O.I), *A Division of the Centers for Advanced Orthopaedics*.

_____ _____
Signature of Patient Date