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

First Name Used ____ Sexual Orientation ____ Gender Identity ____ Assigned Sex at birth ☐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 ____

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

INSURANCE INFORMATION

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

Group No. ____ Claim Address: ____

Policy Holder's Name: ____ Policy Holder's Date of Birth ____

Subscriber's SS# ____ Relationship to Patient ____

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

Group No.: ____ Claim Address: ____

Policy Holder's Name: ____ Policy Holder's Date of Birth ____

Subscriber's SS# ____ Relationship to Patient ____

INJURY - AUTOMOBILE ACCIDENT
(*If Applicable your information is required*)

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 (If Applicable)

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: Do you Smoke? __ Yes __ No Do you Drink Alcohol? __ Yes __ No Do you Exercise Regularly? __ Yes __ No

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

Allergies to Medications: ________________

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 or exercise 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