SUBURBAN ORTHOPAEDIC TOTAL JOINT & SPORTS CLINIC, P.C.

PATIENT DEMOGRAPHIC SHEET

PATIENT INFORMATION

Patient Last Name	First Name		Middle Initial	
Street Address				
City	State	Zip Code	Date of Birth	Age
Home Phone #	Cell Phone #		Work Phone #	
Social Security #	Sex M F		Marital Status _Married _ Single _Divorced _Separated _ Widowed	
Primary Care Physician	PCP Phone #		Referring Physician Name and Phone #	

Occupation	Employer & Address
Email Address	Preferred Pharmacy (Name and Location)
** Patients in our practice may be contacted via voice messaging, email and/or text messaging to remind you of an appointment. I understand that this request to receive voice messages, emails and text messages will apply to all future appointment reminders unless I request a change in writing.** ____ Patient/Guardian Initial	I authorize to receive text messages for appointment reminders to the following: __ Email __Text Message __ Voice Message _____ Signature of Patient/Guardian

EMERGENCY CONTACT INFORMATION

Name	Relationship To Patient
Home Phone #	Cell Phone #

RESPONSIBLE PARTY INFORMATION

Who is Responsible for this bill?			
Name		Relationship to Patient	
Street Address		Phone Number #	
City	State	Zip Code	Social Security #

SUBURBAN ORTHOPAEDIC TOTAL JOINT & SPORTS CLINIC, P.C.

PATIENT MEDICAL HISTORY SHEET

PATIENT INFORMATION

Patient's Name	Date of Birth	Today's Date

Height	Weight	__Left Handed __Right Handed

Reason for Today's Visit	Date Occurred

Rate your pain on a scale of 1-10? (1= no pain, 10= worst pain you have ever had)
(Circle one) 1 2 3 4 5 6 7 8 9 10

Was there an Injury? __Yes __No	Is this related to an Auto Accident? __Yes __No	Is this related to a Work Injury? __Yes __No

If Work Related. Have you reported this injury to your employer?
__Yes __No

TREATMENTS OR TESTS

XRAY __Yes __No	CT Scan __Yes __No	MRI __Yes __No	Injections __Yes __No	Bloodwork __Yes __No

MEDICAL HISTORY

MEDICAL HISTORY	YES	NO	WHEN	DESCRIBE
Heart Disease				
Stroke				
Diabetes				
High Blood Pressure				
Cholesterol				
Vascular/Circulation (Indicate which one)				
Blood Clot- leg or lung (DVT/PE)				
Arthritis (Please indicate type)				
Stomach/Intestine				
Cancer (Please indicate type)				
Bleeding/Clotting Disorder				
HIV				
Nerve/Neurological/Seizures (Indicate which one)				
Asthma/Lung Disease (Indicate which one)				
Kidney				
Thyroid				
Hepatitis/Liver Disease/Cirrhosis				
Depression/Psychiatric				
Severe Sprains/Dislocations/Broken bones (Indicate which one)				
Skin Disorders				
Other				

Reviewed by:_____ Date:_____

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PATIENT MEDICAL HISTORY SHEET

CURRENT MEDICATIONS

** IF POSSIBLE, PLEASE PROVIDE SUBURBAN ORTHOPAEDIC WITH A COPY OF YOUR MEDICATION LIST **

MEDICATIONS	DOSE	WHEN TAKEN	REASON FOR TAKING

PAST SURGERIES

TYPE OF SURGERY	DATE OF SURGERY

ALLERGIES

Type of allergy	Describe Reaction
LATEX ALLERGY? __ Yes __ No	

SOCIAL HISTORY

__Single	__Married	__Divorced	__Separated	__Widowed	__Partner

Do you live alone? __Yes __No	Are you a caregiver for a family member at home? __Yes __No For whom? _____
Do you smoke? __Yes __No	# of packs a day
Do you drink alcohol? __Yes __No	# of drinks per day
Do you use illicit drugs? __Yes __No	

FAMILY HISTORY

Family Member	Age	Alive?	Deceased?	List Illness/Cause of Death

SUBURBAN ORTHOPAEDIC TOTAL JOINT & SPORTS CLINIC, P.C.

HEALTH INSURANCE INFORMATION

Primary Health Insurance	Policy Holder	Relationship
Policy Holder Employer	Occupation	
Date of Birth	Social Security #	Work Phone #
Policy #	Group #	Effective Date
Secondary Health Insurance	Policy Holder	Relationship
Policy #	Group #	Effective Date
Date of Birth	Social Security #	Work Phone #

AUTO ACCIDENT INFORMATION

Auto Insurance Company	Policy Holder	
Address of Auto Insurance Company		
Claim #	Phone #	Date of Accident
State Accident Occurred In		

WORKER'S COMPENSATION – ON THE JOB INJURY

Date of Injury	Was Injury reported to Supervisor? __Yes __No	Claim #
Employer at time of Injury		
Name of Supervisor	Phone #	
Worker's Compensation Insurance		

PATIENT/RESPONSIBLE PARTY AUTHORIZATION AND WAIVER

I, _____, hereby authorize Suburban Orthopaedic to apply for benefits on my behalf or my dependent's behalf for covered services rendered and I hereby authorize suburban Orthopaedic to furnish information to insurance carriers concerning my illness and treatments. I also hereby assign Suburban Orthopaedic all payment for services provided. I also understand it is my responsibility to provide all necessary insurance referrals provided by my primary care physician. If I have an HMO policy, I agree to be personally and fully responsible for payments of services deemed necessary in my or my dependent's medical interest and permit a copy of this authorization to be used in place of the original. This document will act as a promissory note. Suburban Orthopaedic reserved the right to add 1% per month interest charge on accounts 45 days overdue.

_____ _____

Signature of Patient/Guardian Date

SUBURBAN ORTHOPAEDIC TOTAL JOINT & SPORTS CLINIC, P.C.

FOR INSURANCE BILLING PURPOSES

Your Insurance company requires this information, otherwise your claim may be denied and you may be responsible for the bill.

Is this problem resulting from an injury?	__Yes __No
If yes, please answer the next three questions	If no, please check no above and sign and date the bottom
Is this a work related injury?	__Yes __No
Is your injury the result of someone else's fault?	__Yes __No
Is your injury the result of an auto accident?	__Yes __No

Please describe you injury in detail

_____

_____

_____

_____

_____

Patient/Guardian Signature_____ Date_____

SUBURBAN ORTHOPAEDIC TOTAL JOINT & SPORTS CLINIC, P.C.

11701 Livingston Road, Suite 105
Fort Washington, MD 20744

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Patient Name

I hereby authorize the use and disclosure of individually identifiable health information relating to me, which is called "protected health information" under a federal health privacy law, as described below:

I understand that we have no control over the re-disclosure and use of information by entities that you give us permission to release your information to.

Suburban Orthopaedic and its agents may use or disclose your personal health information for your treatment, health care operations or payment process.

Persons You Authorize us to Disclose Your Information to

Family Member	Family Member
Primary Care Physician	Insurance Company
Worker's Compensation	Employer
Other 3rd Party	Legal Counsel
Other	Other

I understand that I may revoke this authorization at any time, and that this revocation must be made to Suburban Orthopaedic in writing. However, if I chose to do so, I understand that my revocation will not affect any actions taken by Suburban Orthopaedic before receiving my revocation.

I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

PATIENT	FOR PERSONAL REPRESENTATIVE (IF APPLICABLE)
Name:	Name of Representative:
Signature:	Relation to Patient:
Date:	Signature:
Date of Birth:	Date:
Social Security #:	