



PATIENT REGISTRATION Complete, read, sign and bring Forms A, B and C to first appointment

A

Date of Appointment _____

Name: Last		First		Middle
Address: Number	Street			Apt #
City		State		Zip Code
Home Phone: ()	Cell Phone: ()	Gender [] F [] M	Marital Status: [] M [] S [] W [] D	
Date of Birth:	Age:	Soc. Sec. #:	Height	Weight: Are you claustrophobic? [] No [] Yes
Occupation:		Employer:		
Business Address:			Work Phone: ()	Ext.

Emergency Contact: Spouse/Parent/Other:	Contact's Home Phone: ()
Address:	Contact's Work Phone: ()

Referred by:	Personal Physician (include address or fax if you want a report sent)

Reason for Visit:	Date of Onset:

Check one of the following choices: [] Work Injury, [] Auto Accident, [] Sports Injury, [] Other Injury/Illness	Where (State or Country):
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Brief Description of How the Injury, Illness or Deformity Occurred:

I Will Be Paying Today By: [] Cash, [] Check, [] Credit Card (Visa or MasterCard)

Primary Insurance Carrier:	ID#:	Group #:
Insured's Name:	Insured's Date of Birth:	Insured's Soc. Sec. #:
Relationship to Patient:	Employer:	
Secondary Insurance Carrier::	ID#:	Group #:
Insured's Name:	Insured's Date of Birth:	Insured's Soc. Sec. #
Relationship to Patient:	Employer:	

If Worker's Compensation or Motor Vehicle Accident: Date of injury or accident (dd-mm-yy)	Insurance Carrier:
Address:	Phone:
Claim #:	Adjuster's Name:

I authorize release of any medical information necessary to process claims from this office and request payment of medical benefits directly to Washington Circle Orthopedics Associates, P.C., Peter A. Moskovitz, M.D., James H. Graeter, M.D. Craig R. Faulks, M.D. and/or David M. Lutton, M.D. Also by my signature, I authorize medical treatment to my minor child listed above if applicable.

Signature:	Date:
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Name:	Date of Birth:	Date:
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MEDICAL HISTORY

HAVE YOU HAD, OR DO YOU NOW HAVE:

<i>(circle or check any that apply)</i>	YES	NO	WHEN	Treatment and Outcome
High blood pressure []; Heart disease []				
Irregular heart beat [], Pacemaker []				
Kidney disease []; Dialysis []				
Stroke; seizures; Neurological disease				
Thyroid disorder; High [], Low []				
Diabetes, take medicine [], insulin []				
Inflammatory disease; Rheumatoid				
arthritis [], Lupus [], IBS [], Gout []				
Stomach pain; Ulcers; Reflux				
Bleeding [] or Clotting [] disorder				
Cancer				
HIV, AIDS, Hepatitis (circle)				
Pulmonary Disease, Asthma				
Surgery (most recent)			Year:	
Other Surgery			Year:	<i>List surgeries on another sheet if needed</i>
Do you smoke or use tobacco?				_____ Packs per day for _____ years
Do you use alcohol?				[] Irregularly, [] Regularly

MEDICATIONS

List all medications you are now taking. Use another sheet if needed

Medication	Dose	How Often?

Are you taking anticoagulants (blood thinners)? [] Yes [] No

ALLERGIES TO MEDICATIONS

Use another sheet if needed	Name of Drug	Type of Reaction
Local anaesthetics		
Pain Medications		
Antibiotics (Penicillin, Sulfa, etc.)		
Anti-inflammatory Drugs (Aspirin/Advil/etc)		
Latex [], Iodine [], Contrast dye []		
Others:		

FINANCIAL ARRANGEMENTS AND HEALTH INSURANCE

Please read, sign and date

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our policy.

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, checks, MasterCard or Visa.

We participate with the following insurance carriers. Please understand that these can change and/or the plans can be very specific within Carriers. It is your responsibility to verify with your insurance prior to your visits that we participate with your particular plan. As a participating physician with the following insurances and others: Carefirst/Blue Cross & Blue Shield of the National Capital Area PPO, Medicare, Mamsi, United Healthcare, OneNet, the First Health and Coventry PPO Networks, Cigna PPO (**Not Dr Graeter**) and Tricare Standard, these claims will be processed directly by this office. If you have a question about your particular insurance please ask the receptionist or billing department. All copayment amounts and non-covered services fees are due at the time of service. You will receive a statement for any other balance, including deductible amounts, which is due and payable immediately upon receipt. It is your responsibility to submit to any other insurance directly for reimbursement.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize however that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract and are unable to verify benefits in advance.
2. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they do not cover. It is your responsibility to understand your benefits and coverage.
3. We do not recognize third party liability. Therefore, if you were injured in an accident and expect to collect damages from a negligent party, you will still be expected to pay your bill in full at the time of treatment. This office does not wait for payment until the case is settled by your attorney or insurance carrier.
4. If we do not participate in your insurance plan, payment in full is expected from you at the time of service. As a courtesy we will file a claim to your insurance carrier with benefits made directly to you, the patient.

We must emphasize that as medical care providers, our relationship is with you, not your insurance company. While the assistance with filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE don't hesitate to ask us. We are here to help you.

I understand and agree that, (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered and if my account is turned over for collection action all applicable fees will be my responsibility. I have read all the information on the sheets provided and have completed the answers on Forms A and B. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information. **Per my insurance my Specialty Physician copayment is _____.**

Signature _____ Date _____