Washington Orthopaedic and Knee Clinic, Inc.

FAIRFAX
8316 Arlington Blvd., Suite 510
Fairfax, VA 22031

WOODBRIDGE
14412 Jefferson Davis Hwy.
Woodbridge, VA 22191

SILVER SPRING
801 Wayne Ave., Suite 102
Silver Spring, MD 20910

Tel: 703-641-5633 • Fax: 703-289-1273

PATIENT REGISTRATION: PLEASE PRINT CLEARLY

LANGUAGE: _____ RACE: _____

PATIENT NAME: (FIRST) _____ (LAST) _____ (MI) _____

HOME ADDRESS: _____ EMPLOYED: _____ STUDENT: FT_____ PT _____

_____ SOC. SEC. #: _____

_____ DOB: _____ AGE: _____ SEX: _____

HOME PHONE: _____ MARITAL STATUS: _____ S _____ M _____ D _____ W

WORK PHONE: _____ CELL PHONE: _____

OCCUPATION: _____ EMERGENCY CONTACT: _____

EMPLOYER: _____ EMERGENCY CONTACT PH#: _____

REFERRING PHYSICIAN: _____ REF PHY PHONE #: _____

REF PHY ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HEALTH INSURANCE INFORMATION / WORKERS COMP INFORMATION:

NAME OF INSURANCE CO: _____ PHONE #: _____

BILLING ADDRESS: _____ CITY: _____

STATE: _____ ZIP CODE: _____ ADJUSTOR'S NAME: _____

ID # / CLAIM #: _____ GROUP #: _____

SUBSCRIBER'S NAME: _____ SUBSCRIBER'S DATE OF BIRTH: _____

EMPLOYER: _____ RELATIONSHIP TO PATIENT: _____

REASON FOR APPOINTMENT:

CHIEF COMPLAINT: _____ DATE PROBLEM STARTED: MONTH_____ DATE_____ YEAR _____

WAS THIS DUE TO AN INJURY: YES OR NO IF RELATED TO AN INJURY, SPECIFY TYPE OF INJURY: AUTO _____

SPORTS RELATED _____ WORKER COMP _____ (IF W/C NEED STATE INJURY OCCURRED IN _____)

OTHER INJURY _____ (PLEASE EXPLAIN) _____

LEGAL CASES:

ATTORNEY NAME: _____ ATTORNEY PHONE #: _____

PATIENT TO FILL OUT ENTIRE PAGE SIDE 1

NEW COMPLAINT HISTORY FORM

Date:_____

Patient Name:_____ DOB_____ Age_____ Sex: M F HT:_____ WT:_____

Appt requested by:_____ Primary Physician:_____

Allergies:_____ Dominant Hand: RT LT

Employer:_____ Type of Work_____ Work Status:_____

Chief Complaint:_____

On a scale of 0 - 10 (10 being the worst) how severe is your pain? _____ Does your pain wake you from sleep? Y N

Pain is:
- Sharp
- Dull
- Throbbing
- Aching
- Stabbing
- Burning
- Constant
- Comes and goes (intermittent)

Other Symptoms:
- Swelling
- Bruising
- Numbness / Tingling
- Popping / Grinding
- Weakness
- Locking / Catching
- Loss of control of bladder or bowel
- Giving Way / Instability
- Weight Loss / Gain
- Night Sweats

What makes your symptoms worse?
- Standing
- Walking
- Lifting
- Exercise
- Twisting
- Bending
- Lying in Bed
- Riding in car
- Driving a car
- Overhead Reaching
- Squatting
- Kneeling
- Stairs
- Sitting
- Coughing
- Sneezing
- Activities
- Pushing
- Pulling

What makes your symptoms better?
- Rest
- Ice
- Heat
- Elevation
- Medication
- Reposition
- Other_____

How did your problem start?

☐ Injury Date
- ☐ Accident _____
- ☐ Work Related _____
- ☐ Sports Related _____
- ☐ Auto Accident _____

☐ No Injury Date
- ☐ Gradual Onset _____
- ☐ Sudden Onset _____

History of Complaint: _____

Head On Broad Side Rear Ended Estimated Speed_____

Restrained? Y N Extent of Damage:_____ Vehicle Totaled Y N

X-RAYS:	Date:	_____	Location:	_____
MRI:	Date:	_____	Location:	_____
NCV / EMG:	Date:	_____	Location:	_____
Other:_____	Date:	_____	Location:	_____

Previous Treatment:

(What helped vs. what did not?_____

Previous Injury:_____ RT LT

Physical Therapy:_____

Injections:_____

Other:_____

Previous Medications:_____

(OVER)

PATIENT TO FILL OUT ENTIRE PAGE SIDE 2

Patient Name:_____ DOB_____ Date:_____

MEDICAL HISTORY

Do you have or have you had any of the following?

	YES	NO		YES	NO
Heart Disease	____	____	COPD	____	____
Malignant	____	____	Asthma	____	____
Hyperthermia	____	____	Emphysema	____	____
Stroke	____	____	Tuberculosis	____	____
Aneurysm	____	____	Ulcers	____	____
High BP	____	____	Reflux Disease	____	____
Abnormal Rhythm	____	____	Thyroid Disease	____	____
Blood Transfusion	____	____	Liver Disease	____	____
Anemia	____	____	Kidney Disease	____	____
Blood Clots	____	____	Renal Failure /		
Bleeding Disorder	____	____	Dialysis	____	____
Hepatitis	____	____	Urinary Problems	____	____
HIV / Aids	____	____	Sleep Apnea	____	____
Depression	____	____	Gout	____	____
Alcoholism	____	____	Neuropathy	____	____
Bipolar	____	____	Osteoarthritis	____	____
Schizophrenia	____	____	Low Back Pain	____	____
Skin Condition	____	____	Osteoporosis	____	____
Diabetes	____	____			
IBS / Diverticulitis	____	____	Implants	____	____
** Cancer	____	____	Pacemaker	____	____

**Location & Year_____

Other:_____

Do you wear / use any of the following?

- ☐ Glasses
- ☐ Contacts
- ☐ Walker / Cane
- ☐ Hearing Device
- ☐ Dentures

List all past surgeries with dates:

_____

_____

_____

_____

_____

_____

ADVANCED DIRECTIVES: YES NO If yes, provide copy

ALLERGIES _____

_____

_____

List all medications you are currently taking:

_____

_____

_____

_____

_____

_____

_____

FAMILY MEDICAL HISTORY

Do any of these problems run in your family?

	YES	NO		YES	NO
Heart Disease	____	____	Asthma	____	____
Stroke	____	____	Gout	____	____
Bleeding Disorder	____	____	Diabetes	____	____
Aneurysm	____	____	Kidney Disease	____	____
Arthritis	____	____	Thyroid Disease	____	____
Malignant			Mental Illness	____	____
Hyperthermia	____	____	Alcoholism	____	____

Cancer --- if yes, what type?_____

SOCIAL HISTORY

What are your current living arrangements?

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed
- ☐ Lives at home
- ☐ Nursing home
- ☐ Skilled care facility
- ☐ Lives with parent(s)

Are you currently pregnant? _____

Number of times pregnant: _____

Number of living children: _____

Do you smoke? Y N PPD / #yrs _____/_____

Do you drink? Y N How much? _____

Recreational Activities:_____

_____

_____

Patient Signature Date

_____

Evaluator Signature Date

_____

MD / FNP Signature Date

Washington Orthopaedic and Knee Clinic, Inc.

GENERAL OFFICE POLICIES

M. M. Malek, M.D., F.A.C.S.
Director

Diplomate, American Board of Orthopaedic Surgery

Fellow, American Academy of Orthopaedic Surgeons

Member, American Orthopaedic Association

Fellow, American College of Surgeons

Member, Arthroscopy Association of North America

Member, American Orthopaedic Society for Sports Medicine

Member, American Association of Hip and Knee Surgeons

Member, International Society of Arthroscopy, Knee Surgery and Orthopaedic Sports Medicine

Member, Osteoarthritis Research Society International

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Please address all correspondence to:
P.O. Box 10626
McLean, VA 22102-9626

It is office policy to verify insurance coverage for the services rendered at our facility prior to your visit. This verification of coverage is NOT A GUARANTEE OF PAYMENT OR ELIGIBILTY; claims will be reviewed by your insurance carrier to determine coverage. It is your responsibility to obtain any referrals required by your insurance company and confirm that we are considered in-network. If you have an HMO plan you must provide a valid referral from your primary care physician to our office.

Co-pay, co-insurance, and deductible payments are to be paid at the time of service in order to be seen. If you are unable to provide payment we will reschedule your appointment for the next available date. This office **DOES NOT** accept large amounts of coins as a form of payment. Any returned checks will be subject to a $35.00 fee on top of the value of the check.

Any costs incurred in connection with the collection of the balance due such as attorney fees, collection agency fees and/or court costs, to satisfy any past due balance will be your responsibility.

A fee of $50.00 will be charged to you for any appointments that are not cancelled within 24 hours.

Forms that are required to be completed by the physician will have an administrative fee of $15.00 (2 pages or less) or $35.00 (3 pages or more). You must complete your portion prior to giving it to the office.

Medical records are kept for a maximum of six years following the last encounter with the physician. There is an $18.00 processing fee plus $0.60 per page for copies of your medical records.

By signing below you acknowledge that you have chosen Washington Orthopaedic and Knee Clinic for treatment and agree to the terms above.

_____

Your printed name or guardian if under age of 18 Date

_____

Your signature or guardian if under age of 18 Date

Legal Cases Only (W/C, Personal Injury, Auto Accidents)
In the event that your case is lost or dismissed you will be responsible for all the charges incurred with this office. We will not bill your health insurance for any outstanding charges regardless of being in-network with your insurance carrier. You must also notify us of any changes with your attorney within 48 hours to avoid immediate billing to you for charges incurred. _____ (Initial here)

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at the any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____

PATIENT CONSENT FORM

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

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Patient Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____