Bone & Joint Specialists of Winchester, P.C.

REGISTRATION FORM
PATIENT INFORMATION

Please Print Legibly And Complete All Information

DATE: _____ CHART#: _____

VERIFY: _____ EMAIL ADDRESS: _____

PATIENT NAME: _____
First Middle Last Maiden

DATE OF BIRTH: _____ AGE: _____ SEX: ☐ MALE ☐ FEMALE

ADDRESS: _____ HOME PHONE: _____

CITY: _____ STATE: _____ ZIP: _____ WORK PHONE: _____

PATIENTS SOCIAL SECURITY #: _____ CELL PHONE: _____

PATIENTS EMPLOYER: _____ EMER. PHONE: _____

EMPLOYER ADDRESS: _____ OCCUPATION: _____

PATIENTS MARTIAL STATUS: ☐ S ☐ M ☐ D ☐ W SPOUSE'S NAME: _____

REFERRING PHYSICIAN: _____
Name Address

GUARDIAN NAME: _____ SS#: _____

GUARDIAN ADDRESS: _____

GUARDIAN EMPLOYER: _____ ADDRESS: _____

INSURANCE INFORMATION

PRIMARY INS. CO. _____

NAME OF POLICYHOLDER: _____ DATE OF BIRTH: _____

RELATIONSHIP OF PATIENT TO POLICY HOLDER: SS#: _____

☐ Self ☐ Husband ☐ Wife ☐ Child ☐ Parent ☐ Other CO-PAY: _____

SECONDARY INS. CO. _____

NAME OF POLICYHOLDER: _____ DATE OF BIRTH: _____

RELATIONSHIP OF PATIENT TO POLICY HOLDER: SS#: _____

☐ Self ☐ Husband ☐ Wife ☐ Child ☐ Parent ☐ Other

THIRD INS. CO. _____

NAME OF POLICYHOLDER: _____ DATE OF BIRTH: _____

RELATIONSHIP OF PATIENT TO POLICY HOLDER: SS#: _____

☐ Self ☐ Husband ☐ Wife ☐ Child ☐ Parent ☐ Other

PHARMACY: _____

PAYMENT GUARANTY AGREEMENT – ASSIGNMENT OF INSURANCE BENEFITS AUTHORIZATION TO RELEASE MEDICAL INFORMATION

In consideration of service rendered to the patient named hereon for this treatment, the undersigned jointly and severally guarantee payment to Bone & Joint Specialists of Winchester, P.C., of all charges incurred on behalf of said patient.

It is understood and agreed upon between BJSW and the undersigned that:

1. Upon demand by BJSW, the undersigned agrees to pay the entire balance due;

2. The undersigned hereby assigns to BJSW with regard to its charges, any and all rights and benefits the undersigned may have under any policy of insurance (hospitalization, major medical, automobile, worker's compensation or any other) and hereby authorizes BJSW and its agents of release what ever medical information necessary to perfect a claim under such policy. Any such billings made directly to such insurance company in no way relieves the undersigned of obligations as stated in this agreement, and I further understand that any pre-admission approval requirements of any policy of insurance are my responsibility, and that I must pay portions of my bill which are not paid by insurance;

3. Finance charge (no charge if paid in 30 days of billing date) is computed bye a "Periodic Rate" of 1 ½% per month, which is an ANNUAL PERCENTAGE RATE of 18% applied to the previous balance without deducting current payments and/or credits appearing on any given charge. Upon default in the payment of the balance owed, the above rate will be charged on the unpaid balance at 1 ½% per month until the delinquency is paid. Guarantor(s) further agree to pay any all collection fees incurred and legal expenses, including but not limited to Collection Agency fees and attorney fees at 33 1/3%, all court related costs, service and filing fees, interrogatory and garnishment fees as well as any interest that may be adjudicated for the collection of past due debt on accounts with this provider.

4. BJSW may make a payment agreement with any or all the undersigned, or any other person liable for the payment of the bill, which agreement shall be considered ancillary to and not in lieu of this agreement. Such payment agreement shall not be construed as limiting or modifying the liability of any person liable for charges and shall not be construed as in any way limiting the right to continue collection action against any person liable for charges hereby;

5. With this consent, Bone and Joint Specialists of Winchester, PC, and it's agents may call my home, my cell phone or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment, and healthcare options, such as appointment reminders, insurance and billing items and any call pertaining to my clinical care, including laboratory results among others.

6. The undersigned hereby states that for the purposes of the assignments and authorizations contained herein, a photocopy of the original executed document shall be as valid as the original and any and all persons affected by the assignment and/or requesting an authorization are hereby directed to honor said copy.

I HAVE EITHER READ OR HAD FULLY EXPLAINED TO ME THIS DOCUMENT.

_____ DATE: _____

PATIENT/GUARANTOR SIGNATURE:

CONCERNING MEDICARE

I hereby authorize Bone & Joint Specialists of Winchester, P.C. to apply for benefits on my behalf for covered services rendered.
I certify that the information I have reported with regard to my insurance coverage is correct. I further authorize the release of any necessary information, including material information for this or any related claim, to my insurance carrier; or, in the case of Medicare Part B benefits to the Social Security Administration and Health Care Financing Administration. I further authorize payment of all medical insurance benefits which are payable to me under the terms of my insurance policy to be paid directly to Bone & Joint Specialists of Winchester, P.C. for services rendered. A copy of the Authorization may be used in place of the original.

This Authorization may be canceled at the request of the patient.

X _____ DATE: _____

LIFETIME SIGNATURE OF PATIENT, INSURED OR BENEFICIARY

NOTICE OF DEEMED CONSENT TO HIV BLOOD TEST

A law was enacted in Virginia in 1989 which authorizes health care providers to test their patients for HIV antibodies when the health care provider is exposed to body fluids of a patient in a manner which may transmit Human Immunodeficiency Virus (HIV). Pursuant to this law, in the event of such an exposure, you will be deemed to have consented to such testing, and to have consented to the release of the test results to the health care provider who may have been exposed. However, you would be informed before any of your blood would be tested for HIV antibodies. Pursuant to this provision, the testing would be explained and you would be given the opportunity to ask any questions you might have.

I HAVE READ AND UNDERSTAND THE ABOVE "NOTICE OF DEEMED CONSENT TO HIV BLOOD TESTING".

X _____ DATE: _____

PATIENTS SIGNATURE

Acknowledgement of Receipt of Privacy Policy

I hereby acknowledge that I have read the
Bone & Joint Specialists
Of Winchester, P.C.
Privacy Practices brochure, located here:
www.BoneAndJointSpecialists.com/about/privacy-policy

_____
Patient Name

_____
Patient or Legal Representative Signature

_____
Date

Information May Be Released To:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

BONE & JOINT SPECIALISTS OF WINCHESTER

NEW PATIENT MEDICAL HISTORY FORM

Patient Name: _____ Height: _____ Weight: _____

Race: African American Asian Caucasian Native American/Alaskan Pacific Islander Other
Unknown Decline to Answer

Ethnicity: Hispanic Non-Hispanic Unknown Decline to Answer

Preferred Language: English Spanish Chinese Other

Preferred Pharmacy: _____

Referral Source: Doctor (name): _____ Other (ex. Google search): _____

Chief Complaint

Dominant Hand: Right Left Ambidextrous

Description of Symptoms: (select only ONE primary symptom and ONE affected area)

Pain Numbness/Tingling Fracture Stiffness Other: _____

Shoulder	Right	Left	Pelvis	Right	Left	Neck
Upper Arm	Right	Left	Hip	Right	Left	Upper Back
Elbow	Right	Left	Thigh	Right	Left	Mid Back
Forearm	Right	Left	Knee	Right	Left	Low Back
Wrist	Right	Left	Lower Leg	Right	Left	Buttocks
Hand	Right	Left	Ankle	Right	Left	Tail Bone
Thumb	Right	Left	Foot	Right	Left	
Index	Right	Left	Great Toe	Right	Left	
Middle	Right	Left	2nd Digit	Right	Left	
Third	Right	Left	3rd Digit	Right	Left	
Little	Right	Left	4th Digit	Right	Left	
			5th Digit	Right	Left	

Pain radiates from/to: (ex. from low back to right leg) _____

History of Present Illness

1. Is your problem the result of an injury or accident?
   No Injury Injury Injury at Work Auto Accident Sport Injury Prior Surgery
   How long have the symptoms been present? (ex. 2 days, 4 months) _____
   Describe the onset: Acute (sudden) Chronic condition (>3 months)
   Onset Date: (mm/dd/yyyy) _____
2. Are you represented by an attorney? Yes No
   Attorney Name: _____
   Will there be any legal actions with respect to this problem? Yes No
3. Have you had a problem like this before? Yes No
   Describe: _____
   _____
4. Have you been seen in an ER for this problem? Yes No
   Treating ER: (ex. St. Luke's Health) _____ Date: (mm/dd/yyyy) _____

 Patient Name: _____

History of Present Illness (continued)

5. Rate the pain (10 being the most pain):

0 1 2 3 4 5 6 7 8 9 10

6. Do the symptoms wake you from sleep?

Yes No

7. Please describe the symptoms:

Sharp Dull Stabbing Throbbing Aching Burning Shooting

8. What is the timing of the symptoms?

Constant Intermittent (comes and goes)

9. Is the problem getting better or worse?

Getting better Getting worse Unchanged

10. What makes the symptoms worse?

Squatting Kneeling Sitting Bending Stairs Twisting Moving Lying in bed
Running Walking Athletics Standing Gripping Lifting Reaching Overhead

11. Are there any other symptoms associated with this problem?

Redness Bruising Swelling Numbness Stiffness Limping Clicking Locking
Popping Tingling Weakness Giving way

Prior Testing / Treatment

Have you had any prior tests for this problem?

None X-rays MRI CT Scan Nerve Test (EMG/NCV) Bone Scan

Have you had any prior treatment for this problem? Yes No

Type of treatment	Status of symptoms after treatment (select only those that apply)			Date of treatment
Ice	Improved	Worsened	Unchanged	
Heat	Improved	Worsened	Unchanged	
Rest	Improved	Worsened	Unchanged	
NSAIDs	Improved	Worsened	Unchanged	_____
Muscle Relaxers	Improved	Worsened	Unchanged	_____
Chiropractor	Improved	Worsened	Unchanged	_____
Physical Therapy	Improved	Worsened	Unchanged	_____
HomeExerciseProgram	Improved	Worsened	Unchanged	_____
Surgery	Improved	Worsened	Unchanged	_____
Injections	Improved	Worsened	Unchanged	_____
Bracing	Improved	Worsened	Unchanged	_____
TENS unit	Improved	Worsened	Unchanged	_____

Other/Comments: _____

_____

_____

 Patient Name: _____

Select all previous hospitalizations/surgeries: None

- Aneurysm (Brain) Surgery
- Aortic Bypass / Vascular Surgery
- Appendectomy
- Cataract (Eye) Surgery
- Cholecystectomy (Gallbladder)
- Heart Surgery
- Hernia Repair
- Hysterectomy
- LAP Band / Gastric Bypass Surgery
- Lumpectomy
- Mastectomy
- Malignancy/Cancer
- Stents

Orthopedic on side: Right Left

- Arthroscopy: Knee
- Arthroscopy: Shoulder
- Carpal Tunnel Release
- Rotator Cuff Repair
- Total Hip Replacement
- Total Knee Replacement
- TotalShoulderReplacement
- Spinal Surgery - Indicate Level: _____

Other Surgery

_____
_____
_____

Other Orthopedic Surgery

_____
_____
_____

Medical Questions

Mark all that currently apply:

Metal in body Claustrophobic Pregnant Sleep Apnea Uses a CPAP Snores

Are you taking blood thinners? Yes No

Review of Systems

Please indicate if you have experienced any of the following symptoms in the last 6 months?

				None for all None	Comments
1) CON	Weight Loss	Loss of Appetite	Fatigue		
2) EYE	Blurred Vision	Double Vision	Vision Loss		
3) ENT	Hearing Loss	Hoarseness	Trouble Swallowing		
4) CV	Chest Pain	Palpitations			
5) RS	Chronic Cough	Pneumonia	Shortness of Breath		
6) GI	Heartburn, Ulcers	Nausea, Vomiting	Blood in Stool		
7) GU	Painful Urination	Blood in Urine	Kidney Problems		
8) SK	Frequent Rashes	Skin Ulcers	Lumps Psoriasis		
9) NEU	Frequent Falls	Loss of Coordination	Numbness		
	Change in Bowel	Change in Bladder	Dizziness		
10) PSY	Depression/Anxiety	Drug/Alcohol Addiction	Sleep Disorder		
11) ENDO	Fever	Heat or Cold Intolerance	Night Sweats		
12) HEM	Easy Bleeding	Easy Bruising	Anemia		

 Patient Name: _____

Family History

Have any direct relatives had any of the following disorders? None for all

Father	None	Diabetes	Heart Disease	Hypertension
	Bleeding Problems	Epilepsy	Connective Tissue	Muscular Dystrophy
	Stroke	Osteoporosis	Rheumatoid Arthritis	Cancer
	Comments (ex. cancer type) _____			
Mother	None	Diabetes	Heart Disease	Hypertension
	Bleeding Problems	Epilepsy	Connective Tissue	Muscular Dystrophy
	Stroke	Osteoporosis	Rheumatoid Arthritis	Cancer
	Comments (ex. cancer type) _____			
Sibling	None	Diabetes	Heart Disease	Hypertension
	Bleeding Problems	Epilepsy	Connective Tissue	Muscular Dystrophy
	Stroke	Osteoporosis	Rheumatoid Arthritis	Cancer
	Comments (ex. cancer type) _____			

Social History

Do you smoke tobacco? Current, every day smoker Current, some day smoker Former smoker Never Heavy tobacco smoker Light tobacco smoker

Do you drink alcohol? Daily Occasionally Rarely Never

Marital Status: Married Single Divorced Widowed Domestic Partnership

Are you currently working? Yes No Retired Disabled If no, what date did you last work? _____

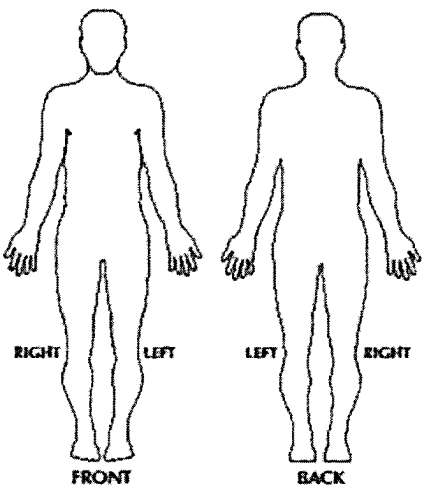
Please list work restrictions, if any: _____

Occupation: _____ Employer: _____ Student

Pain Diagram

On the drawing below, mark an X where the pain is the worst.
Use the symbols below to show where you are having different kinds of pain:

Aching	^^^^
Numbness	====
Pins and Needles	oooo
Burning	xxxx
Stabbing Pain	////



 Patient Name: _____

Do you have any allergies? Yes No If Yes, please list below:

Medication, Relevant Food, or "Seasonal"	Reaction

Latex allergy? Yes No

Please list all medications you take on a regular basis: None

Medication	Dosage and Frequency (e.g. 20 mg, once/day)

Do you have a personal history of any of the following? None

- Aneurysm Where: _____
- Angina (Chest Pain)
- Arthritis Type: _____
- Asthma
- Bone or Joint Infections
- Cancer Type: _____
- Chemotherapy / Radiation
- COPD
- Congestive Heart Failure
- Diabetes Type: _____
- Emphysema
- Epilepsy
- Heart Attack
- Hepatitis Type: _____
- HIV / AIDS
- High Cholesterol
- Hypertension
- Hyperthyroidism
- Hypothyroidism
- Last A1C: _____
- Kidney Disease
- Kidney Stones
- MRSA Infection
- Pacemaker
- Phlebitis (Blood Clots)
- Pulmonary Embolism
- Reaction to Anesthesia Type: _____
- Seizures
- Stomach Ulcers
- Stroke / TIA
- Tuberculosis

Please list any other conditions or details of conditions marked above:

_____

_____

_____

_____

_____

_____

_____ _____

Signature Date

How Did You Hear About

Bone & Joint Specialists of Winchester?

Please check all that apply and give specifics in available spaces.

- ☐ Sporting Event
- ☐ Newspaper Which One? _____
- ☐ Newspaper Advertisement Which Newspaper? _____
- ☐ Website (www.boneandjointspecialists.com)
- ☐ Internet Search
- ☐ Referred by a Friend/Relative

  Who? _____

  Was this person a prior patient? _____
- ☐ Referral from Emergency Room Which One? _____
- ☐ Referral from Urgent Care Center Which One? _____
- ☐ Referral from Physician Dr. _____
- ☐ Referral from Physical Therapist Which One? _____
- ☐ Yellow Pages
- ☐ Facebook (Bone & Joint Specialists)
- ☐ Radio Advertisement Which One? _____
- ☐ Hospital/Valley Health Website
- ☐ Other _____

Which one mattered most? _____

Thank you.

Please Print and bring completed form to your visit.