MONTGOMERY ORTHOPAEDICS, PA

Consent to the Use and Disclosure of Health Information
for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have seen a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will post a copy of a revised notice in the office. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information: _________NONE

____
____

Signature of Patient or Legal Representative Witness

_______Accepted ________ Denied

Signature______________________________ Date: ________________________________

Consent To Telephone Contact By Office Staff

I understand that as part of my healthcare, this organization places reminder calls to the patient one (1) to two(2) days prior to appointment. The information that will be disclosed is your name, appointment date and time, the physician you are seeing and requests for referral, x-ray/MRIs and patient balances due, if applicable. This form gives Montgomery Orthopaedics authorization to contact you as follows: (Please answer question with YES or NO)

1. __________ I maybe contacted at Home
2. __________ I maybe contacted at Work(phone # , ext________________)
3. __________ You may speak to anyone who answers my phone
4. __________ You may only speak to_________________________________
5. __________ You may leave a message on my answering machine.

Signature of Patient or Legal Representative Witness

_______Accepted ________ Denied

Signature______________________________ Date: ________________________________

Clifford Hinkes M.D. Philip L. Schneider, M.D. Daniel J. Pereles, M.D. Antoni B. Goral, M.D. Harrison B. Solomon, M.D.
10400 Connecticut Ave Concourse Level Kensington, Maryland 20895 (301) 949-8100

MONTGOMERY ORTHOPAEDICS, PA

Please Print Clearly

Patient Information

Acct #_______________ Date: ________________

First Name Middle Last	Age	Sex
Street Address City State Zip		

Home Phone	Work Phone with Ext#	Birth date	Social Security #

Employer	Employer Address

Next of Kin/Emergency Contact Name	Relationship to Patient	Phone #

Primary Care Physician: Address:	Primary Care Phone #:

Individual Responsible for Payment

First Name Middle Last	Birth date
Street Address City State Zip	

Home Phone	Work Phone	Employer	Social Security #
Employer Address			

Date of Injury, Accident *OR* Onset of Symptoms This information is required

Date of Injury:	Date of Accident :	Date of Onset of Symptoms:

Injured on the job? Y N	Work Comp Claim Number	Automobile or other accident? Y N	Auto Claim Number

Primary Insurance Company

Name	Policy ID No.	Group #
Insurance Street Address City State Zip		
Name of Policy Holder		

Birthdate of Primary Policy Holder	SS# of Primary Policy Holder	Relationship to Insured

Secondary Insurance Company

Name	Policy ID No.	Group #
Insurance Street Address City State Zip		
Name of Policy Holder		

Birthdate of Secondary Policy Holder	SS# of Secondary Policy Holder	Relationship to Insured

Patient Attestation

Signature____Date______________________________________

Information For Your Physician

MONTGOMERY ORTHOPAEDICS, PA
10400 Connecticut Ave
Kensington, Maryland 20895

Date:

SSN #:

Date of Birth:

Name:

Age:

What Is Your Main Reason for Seeking Medical Care?

Describe Briefly What Happened:

What Are Your Main Symptoms:

How severe is the pain/problem?

Does the pain /problem occur at a specific time? When?

Date or Onset of Current Accident/injury/problem

Nature of Accident: ____ Car ____ Motorcycle ____ Bike ____ Pedestrian ____ Work Related ____ Home ____ Sports ____ Other:

Have You Had Same or Similar Symptoms Before? If Yes, When?

Were You Seen by Another Physician or Hospital for this injury/problem? ___ No ___ Yes Date:

Physician:

Hospital/Facility:

X-rays? ___ No ___ Yes

Date:

Have You Had Serious Injuries / Broken Bones? ___ No ___ Yes List:

Previous Surgeries (Dates & Surgeon):

Illnesses Which Required Hospitalization but Not Surgery:

Medications (Name, Otherwise Identify Medicines, Now or Recently Used):

Allergy or Sensitivity to Medicine or Other Substances? ___ No ___ Yes List:

Check Any Conditions/Illnesses/Treatment You Have/had: ___Cancer ___ Heart Disease ___ Heart Attack ___ Diabetes

___Jaundice ___ Bleeding Tendencies ___ Kidney disease ___ Hypertension ___ Gout ___ Asthma ___ Drug Rehab

___ Nervous Disorder ___ Venereal Disease ___ HIV Pos ___ Other:

Martial status: _____Single _____Married _____Separated _______Divorced______Widowed

Use of alcohol: ______Never ______Rarely _______Moderate ______Daily

Use of Tobacco:

Amount?

Use of drugs:____Never

Type/ Frequency

Onset of LMP:

Are You Pregnant?

Dressed Weight?

Family Medical History	Age	Diseases	If deceased, cause of death
Father			
Mother			
Siblings			
Spouse			
Children			

Reviewed By:

Date:

Office use Only

Sitting BP________
Height___________
Weight__________
Temp.__________
Heart rate________
Resp. rate_______

Date: ____/____/___	**SSN #:**	**Date of Birth:** ____/____/___
Name:		**Age:**

Please Circle Each Question

• CONSTITUTIONAL SYMPTOMS		
	Good general health lately	No Yes
	Recent weight change	No Yes
	Fever	No Yes
	Fatigue	No Yes
	Headaches	No Yes
• EYES		
	Eye disease or injury	No Yes
	Wear glasses/contact lens	No Yes
	Blurred or double vision	No Yes
	Glaucoma	No Yes
• EARSINOSE/MOUTH/THROAT		
	Hearing loss or ringing	No Yes
	Earaches or drainage	No Yes
	Chronic sinus problem or rhinitis	No Yes
	Nose Bleeds	No Yes
	Mouth sores	No Yes
	Bleeding gums	No Yes
	Bad breath or bad taste	No Yes
	Sore throat or voice change	No Yes
	Swollen glands in neck	No Yes
• CARDIOVASCULAR		
	Heart trouble	No Yes
	Chest pain or angina pectoris	No Yes
	Palpitation	No Yes
	Shortness of breath with walking or lying flat	No Yes
	Swelling of feet, ankles or hands	No Yes
• RESPIRATORY		
	Chronic or frequent coughs	No Yes
	Spitting up blood	No Yes
	Shortness of breath	No Yes
	Asthma or wheezing	No Yes
• GASTROINTESTINAL		
	Loss of appetite	No Yes
	Change in bowel movements	No Yes
	Nausea or vomiting	No Yes
	Frequent diarrhea	No Yes
	Painful bowel movements or constipation	No Yes
	Rectal bleeding or blood in stool	No Yes
	Abdominal pain or heartburn	No Yes
	Peptic ulcer (stomach or duodenal)	No Yes
• GENITOURINARY		
	Frequent urination	No Yes
	Burning or painful urination	No Yes
	Blood in urine	No Yes
	Change in force of strain when urinating	No Yes
	Incontinence or dribbling	No Yes
	Kidney stones	No Yes
	Sexual difficulty	No Yes
	Male - testicle pain	No Yes
	Female - pain with periods	No Yes
	Female - irregular periods	No Yes
	Female - vaginal discharge	No Yes
Female - # pregnancies _____ # miscarriages_____		
Female - date of last pap smear		

• MUSCULOSKELETAL		
	Joint pain	No Yes
	Joint stiffness or swelling	No Yes
	Weakness of muscles or joints	No Yes
	Muscle pain or cramps	No Yes
	Back pain	No Yes
	Cold extremities	No Yes
	Difficulty in walking	No Yes
•INTEGUMENTARY (skin, breast)		
	Rash or itching	No Yes
	Change in skin color	No Yes
	Change in hair or nails	No Yes
	Varicose veins	No Yes
	Breast pain	No Yes
	Breast lump	No Yes
	Breast discharge	No Yes
•NEUROLOGICAL		
	Frequent or recurring headaches	No Yes
	Light headed or dizzy	No Yes
	Convulsions or seizures	No Yes
	Numbness or tingling sensations	No Yes
	Tremors	No Yes
	Paralysis	No Yes
	Stroke	No Yes
	Head injury	No Yes
• PSYCHIATRIC		
	Memory loss or confusion	No Yes
	Nervousness	No Yes
	Depression	No Yes
	Insomnia	No Yes
•ENDOCRINE		
	Glandular or hormone problem	No Yes
	Thyroid disease	No Yes
	Diabetes	No Yes
	Excessive thirst or urination	No Yes
	Heat or cold intolerance	No Yes
	Skin becoming dryer	No Yes
	Change in hat or glove size	No Yes
•HEMATOLOGIC/LYMPHATIC		
	Slow to heal after cuts	No Yes
	Bleeding or bruising tendency	No Yes
	Anemia	No Yes
	Phlebitis	No Yes
	Past transfusion	No Yes
	Enlarged glands	No Yes
•ALLERGIC/IMMUNOLOGIC	History of skin reaction or other adverse reaction to:	
	Penicillin or other antibiotics	No Yes
	Morphine, Demerol, or other narcotics	No Yes
	Novocain or other anesthetics	No Yes
	Aspirin or other pain remedies	No Yes
	Tetanus antitoxin or other serums	No Yes
	Iodine, methiolate or other antiseptic	No Yes
Other drug Or medications ___________________________________		
Known food allergies ___________________________________		

MONTGOMERY ORTHOPAEDICS, P.A.

FAAOS
Diplomates, American Board
of Orthopaedic Surgery

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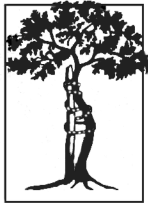


Orthopaedic Surgery
Sports Medicine
Spine Surgery
Arthroscopic Surgery
Hand Surgery
Joint Replacement
Fractures

facsimile transmittal

To: Registration Department Fax: 301-962-7450

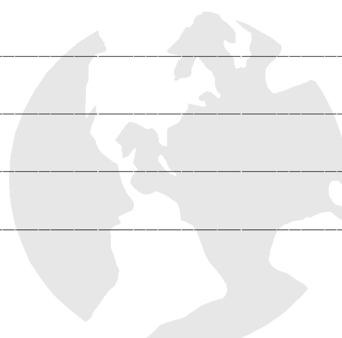
From: Date:

Re: Registration Forms Pages:

CC:

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

Notes:



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