ORTHOPAEDIC MEDICINE AND SURGERY
1850 M Street NW • Washington, DC 20036 • (202) 835-2222
PATIENT INFORMATION SHEET

Appointment Date: ___/___/___ Time: ___: ____ AM / PM Today's Date: _____

PLEASE PRINT

Patient's Last Name:_____ First Name:_____ Middle Initial:____

Address:_____ Sex: Male or Female
Number and Street City State Zip Code

Employer:_____ Occupation: _____

Employer's Address:_____

Home Phone:(____)_____ Work Phone:(____)_____ Cell Phone:(____)_____ Email: _____
Area Code Area Code Area Code

Date of Birth:_____ Age:_____ SSN#_____ Martial Status: Single • Married • Separated • Widowed • Divorced

Spouse's Name:_____ Telephone Number:_____ (Home • Work • Cell)

Emergency Contact:_____ Relation to Patient:_____ Telephone Number:_____

If referred by a physician:
Name of Referring MD:_____ Telephone Number: _____

Primary Care Physician:_____ Telephone Number: _____

Name of Physician you are seeing today (Please Circle)

Louis E. Levitt, MD • Marc B. Danziger, MD • Mark J. Scheer, MD • Noah M. Raizman, MD • Benjamin E. Stein, MD

PRIMARY INSURANCE INFORMATION

Insurance Company Name:_____ Group#_____ ID/Policy# _____

Insurance Company Address:_____ Telephone number:_____

Subscriber's Last Name:_____ First Name:_____ MI:_____ Sex: Male or Female

Subscriber SS#_____ Date of Birth:_____ Relation to Patient: _____

SECONDARY INSURANCE INFORMATION

Insurance Company Name:_____ Group#_____ ID/Policy# _____

Insurance Company Address:_____ Telephone number:_____

Subscriber's Last Name:_____ First Name:_____ MI:_____ Sex: Male or Female

Subscriber SS#_____ Date of Birth:_____ Relation to Patient: _____

Legal Name:_____ Martial Status: Single • Married • Separated • Widowed • Divorced

Employer's Name:_____ Occupation:_____ Work Number:(____) _____

Employer's Address: _____

Date of injury/onset of condition: _____

How and where did the injury occur: _____

_____

Is this visit the result of an accident: _____ NO _____ YES If YES, please indicate: Worker's Comp :____ Auto: _____ Other:_____

We do not recognize third party liability. You will be responsible for payment of all charges at the time of treatment.

WORK RELATED INJURY

(Only complete this section if your injury is work related)

Date of injury/onset of symptoms: _____

Compensation Insurance Carrier Name: _____

Insurance Company Address:_____ Phone: (_____) _____
Area Code

Employer: _____ Employer's Phone: (_____) _____
Area Code

Employer's Address: _____

Was the injury reported to the Supervisor/Employer? Yes _____ No _____ Supervisor's Name: _____

ATTORNEY REPRESENTATION

(Only Complete if an attorney is representing you for your injury)

Attorney's Name: _____ Phone: (_____) _____
Area Code

Attorney's Address: _____

PLEASE READ AND SIGN

I, the undersigned, hereby authorize Louis E. Levitt, MD, Marc B. Danziger, MD, Mark J. Scheer, MD, and/or Noah M. Raizman, MD to apply for benefits on my behalf for covered services rendered to me by one of the above.

I authorize payment directly to the Practice for services for which the Practice accepts assignment.

I, the undersigned, realize that I am financially responsible for all services rendered to me by Orthopaedic Medicine and Surgery. I understand that payment for services is not contingent on recovery and that this does not relieve me of my personal, primary obligation to pay for services rendered and any costs incurred in the collection of these charges, including reasonable attorneys fees.

For those insurances for which the Practice accepts assignment, I realize that I am personally responsible for all co-payments, deductibles and non-covered services as dictated by my insurance coverage.

I authorize the Practice to release to my insurance carrier(s)/employer/attorney any medical information necessary to obtain reimbursement.

I certify that the above information is correct. I permit a copy of this authorization to be use in place of the original.

**** IF UNABLE TO KEEP AN APPOINTMENT KINDLY GIVE 24 HRS NOTICE. OTHERWISE ****
WE RESERVE THE RIGHT TO CHARGE $25.00 FOR TIME RESERVED.

_____ _____
Signature of Patient or Parent/Legal Guardian Date

Date of injury/onset of condition: _____

How and where did the injury occur: _____

_____

Is this visit the result of an accident: _____ NO _____ YES If YES, please indicate: Worker's Comp :____ Auto: _____ Other:_____

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Area Code

Employer: _____ Employer's Phone: (_____) _____
Area Code

Employer's Address: _____

Was the injury reported to the Supervisor/Employer? Yes _____ No _____ Supervisor's Name: _____

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(Only Complete if an attorney is representing you for your injury)

Attorney's Name: _____ Phone: (_____) _____
Area Code

Attorney's Address: _____

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_____ _____
Signature of Patient or Parent/Legal Guardian Date

ORTHOPAEDIC MEDICINE AND SURGERY

(PLEASE PRINT)

Today's Date: _____

Patient's Name: _____ Height: _____ Weight: _____

Reason for visit today: (Please describe in detail your injury or problem)

_____

_____

_____

_____

_____

CURRENT MEDICATIONS

Name	Dose	Frequency	Reason

HEALTH HABITS/DIETARY SUPPLEMENTS

Vitamins Yes No _____

Calcium Yes No _____

Estrogen Yes No

Tobacco Yes No If yes, what type/how often? _____

Have you ever used/smoked? Yes No If yes, date you quit: _____

Alcohol Yes No If yes, amount/how often? _____

Coffee/Tea Yes No _____ Cups a day

Exercise Yes No If yes, amount/type? _____

HOSPITALIZATIONS/OPERATIONS

Reason	Date

What other information should your doctor be aware of?

_____

_____

_____

Patient Statement: To the best of my knowledge, the above information is accurate and complete.

Sign: _____ Date: _____

PHYSICIAN USE ONLY: Reviewed by _____ Date: _____