OrthoBethesda

J. Patrick Caulfield, M.D. ● Edward J. Bieber, M.D. ● Ira D. Fisch, M.D. ● Andre R. Gazdag, M.D. ● Kurt C. Schluntz, M.D.
Christopher J. Cannova, M.D. ● Mahidhar M. Durbhakula, M.D. ● Navin S. Sethi, M.D. ● Sridhar M. Durbhakula, M.D.

Please Print *This information is required by insurance companies.* Chart #_____

PATIENT NAME: First Middle Last ☐Dr. ☐Mr. ☐Mrs. ☐Ms.					HOME PHONE ( )
ADDRESS: Street Apt. # City State Zip Code					WORK / SCHOOL PHONE ( )
GENDER ☐ Male ☐ Female	DATE OF BIRTH	AGE	MARITAL STATUS	SOCIAL SECURITY NUMBER	CELL PHONE ( )
EMAIL ADDRESS					
OCCUPATION	PATIENT'S EMPLOYER / SCHOOL NAME AND ADDRESS				
EMERGENCY CONTACT NAME	RELATIONSHIP TO PATIENT			PHONE NUMBER ( )	

If patient is under 18 years of age, please complete the following:

ACCOMPANYING ADULT'S NAME	RELATIONSHIP TO PATIENT	SIGNATURE

If patient is staying at a Skilled Nursing Facility, please complete the following:

FACILITY NAME	FACILITY ADDRESS	FACILITY PHONE NUMBER ( )

PERSON FINANCIALLY RESPONSIBLE (if other than patient):

NAME	PATIENT'S RELATIONSHIP TO RESPONSIBLE PARTY ☐ Child ☐ Spouse ☐ Other_____	HOME PHONE NUMBER ( )	WORK PHONE NUMBER ( )

CONDITION INFORMATION

INJURED BODY PART	SIDE ☐ Right ☐ Left	DATE PROBLEM BEGAN OR OF THE MOST RECENT FLARE-UP
PRIMARY CARE PHYSICIAN'S NAME	REFERRING **PHYSICIAN**, IF DIFFERENT	

AUTO ACCIDENT? STATE ☐ Yes ☐ No	WORK-RELATED ACCIDENT? STATE ☐ Yes ☐ No	OTHER ACCIDENT? ☐ Yes ☐ No	DATE OF ACCIDENT
IS AN ATTORNEY HANDLING THIS CASE? ☐ Yes ☐ No	NAME AND TELEPHONE NUMBER OF ATTORNEY ( )		DO YOU HAVE A LIVING WILL? ☐ Yes ☐ No

PLEASE CHECK APPROPRIATE BOX **HEALTH** ☐ **PIP / AUTO** ☐ **WORKERS COMP** ☐ **SELF-PAY** ☐

PRIMARY INSURANCE

INSURANCE COMPANY NAME	POLICY NUMBER	GROUP NUMBER	EFFECTIVE DATE	INSURANCE COMPANY PHONE ( )
INSURANCE ADDRESS: Street City State Zip Code			POLICY IN NAME OF	
PATIENT'S RELATIONSHIP TO INSURED	INSURED'S SOCIAL SECURITY #	INSURED'S DATE OF BIRTH	INSURED'S GENDER ☐ Male ☐ Female	INSURED'S EMPLOYER NAME

SECONDARY INSURANCE ☐ **Medigap** ☐ *Please Check*

INSURANCE COMPANY NAME	POLICY NUMBER	GROUP NUMBER	EFFECTIVE DATE	INSURANCE COMPANY PHONE ( )
INSURANCE ADDRESS: Street City State Zip Code			POLICY IN NAME OF	
PATIENT'S RELATIONSHIP TO INSURED	INSURED'S SOCIAL SECURITY #	INSURED'S DATE OF BIRTH	INSURED'S GENDER ☐ Male ☐ Female	INSURED'S EMPLOYER NAME

Patient Acknowledgment

I certify that the information I have reported above is true and correct. I authorize the release of any necessary information, including medical information, for this or any related claim to my insurance company in order to determine payable benefits. I request that payment of authorized benefits be made payable to OrthoBethesda on my behalf. I will notify this office of any changes in my health insurance coverage.

_____ _____

Signature of Patient, Policy Holder or Legal Guardian Date

Printed Name:_____

☐ I have received a copy of the Notice of Privacy Practices for OrthoBethesda.

☐ I have been offered a copy of the Notice of Privacy Practices for OrthoBethesda but did not want a copy.

Please read and sign the back of this form. ⇨