

# Bone & Joint Specialists of Winchester, P.C.

## REGISTRATION FORM PATIENT INFORMATION

PLEASE PRINT LEGIBLY AND COMPLETE ALL INFORMATION

DATE: \_\_\_\_\_

CHART #: \_\_\_\_\_

VERIFY: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_  
First Middle Last Maiden

DATE OF BIRTH: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ AGE: \_\_\_\_\_ SEX: MALE FEMALE

ADDRESS: \_\_\_\_\_ HOME PHONE: ( ) \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ WORK PHONE: ( ) \_\_\_\_\_

PATIENT'S SOCIAL SECURITY #: \_\_\_\_\_ EMER. PHONE: ( ) \_\_\_\_\_

PATIENT'S EMPLOYER: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

EMPLOYER ADDRESS: \_\_\_\_\_

PATIENT'S 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 \_\_\_\_\_

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 \_\_\_\_\_

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

In consideration of services 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 by a "Periodic Rate" of 1 1/2% 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 1/2% per month until the delinquency is paid. Guarantor(s) further agree to pay any and 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. 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.

PATIENT/GUARANTOR SIGNATURE:

DATE: \_\_\_\_\_

**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 TESTING**

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 \_\_\_\_\_  
PATIENT'S SIGNATURE



Acknowledgement  
of  
Receipt  
of  
Privacy Policy

I hereby acknowledge receipt of the  
Bone & Joint Specialists  
Of Winchester, P.C.  
Privacy Practices brochure.

\_\_\_\_\_  
(Patient Name)

\_\_\_\_\_  
(Patient or Legal Representative Signature)

\_\_\_\_\_  
(Date)

Information May Be Released To:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



# Bone & Joint Specialists of Winchester, P.C.

Patient Demographics

Page 1 of 3

Date \_\_\_\_\_

Patient's Name: Last \_\_\_\_\_ First \_\_\_\_\_ MI: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ If Minor, Parent's Name: \_\_\_\_\_

**OFFICE USE ONLY** Weight: \_\_\_\_\_ Height: \_\_\_\_\_ BP: \_\_\_\_\_ P: \_\_\_\_\_

## REFERRAL INFORMATION

Referring Physician: \_\_\_\_\_ Family Physician: \_\_\_\_\_  
Reason for visit: \_\_\_\_\_

Injured? YES or NO If yes, date of injury: \_\_\_\_\_ If yes, how did it occur? \_\_\_\_\_

Physician Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please complete this questionnaire. It will serve as an important part of your medical record. Each time you return, you should inform your doctor of any changes in your health status and of any change in the medications you are using.**

## MEDICAL HISTORY

Previous surgery and procedures: (What, When, Where, and Name of Surgeon)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medication Allergies:** YES or NO What to? \_\_\_\_\_

Current medications:

Name	Dosage	Name	Dosage

## SOCIAL HISTORY

	YES	NO	Amount/Number of Years	When did you quit?
Alcohol Use:	___	___	_____	_____
Cigarette/Other Use:	___	___	_____	_____
Drug Use:	___	___	_____	_____
Occupation: _____			Heavy lifting? _____	How heavy? _____
Duties: _____				
Do you spend a lot of time on your feet? _____			Hours per day: _____	





# 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](http://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 return to receptionist)