J. Richard Wells Orthopaedics, 5530 Wisconsin Avenue, Suite 915, Chevy Chase, MD 20815

PATIENT INFORMATION

LAST Name: ________________________ **FIRST Name**: ___________________________ M.I. _____ Age: _________

Today's Date: _______________ Social Security No: ______________________ Date of Birth: ____/_____/_____ M / F

Mailing Address: ____

City _________________ State__________ Zip _____________ Marital Status: ☐Single ☐ Married ☐Divorced ☐Widow(er)

Home Phone No. ( ) __________________ Work Phone No. ( ) __________________

☐ Employed ☐ Retired ☐ Student:
Employer: _____________________________________ Occupation____

REFERRING PHYSICIAN ____ Phone No: _______________________

SPOUSE or GUARDIAN: Name: ____________________________________ Phone No(s): __________________

RESPONSIBLE PARTY: ☐ Self. If other than self, please fill out the following:

Name of Person Responsible for this Account: _______________________________________ Relationship: ______________

Mailing Address: ____Phone No: __________________

Is today's visit related to: ☐ Worker's Comp ☐ Auto Accident - If so, please fill in the back completely.

PRIMARY INSURANCE: _____________________________ ID #. _________________________Group #:______________

Address to Mail Claim: ____ Effective Date: ____________________

Subscriber NAME____ **Subscriber SS#:** ______________________________

Subscriber Address: ☐ (same as patient) ____

Subscriber DOB: ____ Relationship to patient: _________________________

SECONDARY INSURANCE: : ____________________________ ID #. ________________________ Group #:___________

Address to Mail Claim: ____ Effective Date: ____________________

Subscriber NAME____ **Subscriber SS#:** ____________________________

Subscriber Address: ☐ same as patient) ____

Subscriber DOB: ____ Relationship to patient: _________________________

*** ___ ***Highlighted areas are very important to be filled in if patient is not the subscriber..***

FOR MANAGED CARE PATIENTS:
What is your copay? __________ If required, did you bring a referral form from your PCP? ☐Yes ☐ No ☐N/A
Please note that if your insurance requires a referral for today's visit or any other future visits, it is your responsibility to obtain one. Otherwise, you will be billed in full for services being rendered.

How will you be paying for today's visit? ☐ Check ☐ Mastercard ☐Visa ☐Cash

PLEASE COMPLETE INFORMATION REQUESTED ON THE REVERSE

GENERAL MEDICAL INFORMATION

Which Area of the Body is Reason for Today's Visit ____________________________ Date of injury/illness: ___________

PAST MEDICAL HISTORY:
Current Medications: ____

Are you allergic to any medications/anesthetics: □No □Yes - Specify:____________________________________

Current Significant Medical Conditions: ____

Have you been hospitalized for the condition you are being seen for today? □ Yes □ No

Were x-rays/CT/MRI or other tests taken? Please specify: ____

WOMEN ONLY: Are you pregnant or think you might be pregnant: □ Yes □ No

CLAIMS INFORMATION

Is your visit due to: □ Worker's Comp. □ Auto Injury □ Other Legal______________________________________

Date of Injury: _____________ Time: ______ State where the accident occurred _______________

Insurance Carrier (Where we can send claims to): ____

Insurance Address and Phone no:____

Claim #: ______________________________________ Claims Adjuster Name _________________________________

Attorney's Name:____
Address ____ Phone ______________________

If the above information is not provided, all bills will be sent to the patient and/or guardian for full payment.

I, __________________________, hereby authorize J.Richard Wells, M.D. to apply for benefits on my behalf for covered services rendered and request that payment from my insurance listed above be made directly to J.Richard Wells, M.D. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information including medical information for this on any related claim, to our billing agent, Medicare. I permit a copy of this authorization to be used in place of the original. This authorization can be revoked by either me or the above-named carrier at any time in writing.

I, the patient (or the Guardian/parent of the patient) understand that I am responsible for all professional services' bill that are rendered to me.

____ ________________________
Signature of Patient/Guardian Today's Date