

# **Orthopedic Surgery of Quincy, Inc.**

909 Hancock Street

Quincy, MA. 02170

Telephone 617-773-7457 – Fax 617-773-0299

## ***Welcome To Our Office!***

We welcome you if you are a new patient or a returning patient. We would like you to know that we are here for you and will make your visit as comfortable and timely as possible. We do have office and payment policies you need to know about.

Payment is due at the time of service unless arrangements have been made in advance. We accept MasterCard, Visa and Debit Cards.

It is the patient's responsibility to obtain a referral prior to your visit here. If your primary care physician has not done your referral, you will be asked to sign a waiver or you will not be seen. If your primary care physician does not issue a referral, you will be responsible for payment of the bill. Please keep in mind that your insurance policy is a contract between you and your insurance company. As a service to you, we will file your insurance claim with your insurance company.

Not all insurance plans cover *all* services. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

We will bill your insurance company for any hospital services provided by our physicians. You will be responsible for any balances due.

You must supply our office with a copy of your health insurance card each time you come for a visit. If you do not have your insurance card with you, your insurance company cannot be billed until a copy of your insurance card is received.

***All Insurance co-pays are due at the time of the visit.***

If you cannot keep your appointment, please call to let us know so that we may schedule another patient in need.

We strive to get you seen on a timely basis, but by the nature of the business, emergencies may arise. If we need to reschedule your appointment, we will make every effort to accommodate your schedule.

If you have any questions regarding these policies, please contact the Practice Administrator, Sandra Fencer. She can be reached at 617-773-7457.

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**Patient Registration Form**

Social Security Number: \_\_\_\_\_ Age: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Patient Sex: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Employer: \_\_\_\_\_

Provider: DiCecca/Heller/Rosen/Berkson Primary Care Physician: \_\_\_\_\_  
Please Circle

Primary Insurance Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Subscriber: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Secondary Insurance Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Subscriber: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

**PLEASE GIVE THE RECEPTIONIST YOUR INSURANCE CARDS TO BE COPIED**

WORKERS COMPENSATION-If this is a work related injury, you will be given another form to fill out.

AUTO ACCIDENT-If this injury is related to an auto accident, you will be given another form to fill out.

I authorize the release of all medical information necessary to process insurance claims for my services. I also authorize payment of medical benefits directly to Orthopedic Surgery of Quincy, Inc.

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

**IMPORTANT REFERRAL NOTICE: If you have insurance that requires referrals from your primary care physician for services by a specialist, it is your responsibility to provide this office with a referral for all services. Even if worker's compensation or other insurance is your primary insurance at the time of your office visit, you must obtain a referral so that we may bill your health insurance carrier if your claims are denied by your primary insurance carrier. If you do not have a proper referral, we have the right to refuse to see you today.**

# ORTHOPEDIC SURGERY OF QUINCY, INC.

## Past Medical History

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Do You Use or Require a Cane or Brace? (circle one)      Yes      No

Allergies (medications or dyes):

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

Medications with doses:

1. \_\_\_\_\_ 2. \_\_\_\_\_  
3. \_\_\_\_\_ 4. \_\_\_\_\_  
5. \_\_\_\_\_ 6. \_\_\_\_\_

Past Surgeries:

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

Have you had a problem with anesthesia? \_\_\_\_\_ Explain: \_\_\_\_\_

Medical History: (check all that apply)

|  |   |  |
|--|---|--|
| <input type="checkbox"/> Asthma          | <input type="checkbox"/> Seizures                 | <input type="checkbox"/> Heart Attack      |
| <input type="checkbox"/> AIDS            | <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Abnormal EKG      |
| <input type="checkbox"/> Alcoholism      | <input type="checkbox"/> Blood pressure problems  | <input type="checkbox"/> Cancer (type)     |
| <input type="checkbox"/> Anemia          | <input type="checkbox"/> Ulcer/GERD/Hiatal hernia | <input type="checkbox"/> Hepatitis (type)  |
| <input type="checkbox"/> Brain Tumor     | <input type="checkbox"/> Aneurysm                 | <input type="checkbox"/> Osteoporosis      |
| <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Migraine                 | <input type="checkbox"/> Lung Problems     |
| <input type="checkbox"/> Thyroid         | <input type="checkbox"/> Gout                     | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Angina          | <input type="checkbox"/> Tuberculosis             | <input type="checkbox"/> Pneumonia         |

Last physical exam date: \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Have you recently experienced any of the following?:

|   |  |  |
|---|--|--|
| <input type="checkbox"/> Fever          | <input type="checkbox"/> Shortness of Breath   | <input type="checkbox"/> Loss of urine     |
| <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Bloody bowel movement | <input type="checkbox"/> Chest pain        |
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Muscle cramps         | <input type="checkbox"/> Bleeding tendency |
| <input type="checkbox"/> Nausea         | <input type="checkbox"/> Joint pain            | <input type="checkbox"/> Jaundice          |

Do you smoke tobacco? \_\_\_\_\_ If so, for how long? \_\_\_\_\_

Alcohol use? (circle one)      None      Socially      Heavily

What type of work do you do? \_\_\_\_\_

If out of work, for how long and why? \_\_\_\_\_

Please list family members who have had any of the following problems:

Cancer \_\_\_\_\_ Stroke \_\_\_\_\_ Diabetes \_\_\_\_\_ Heart Disease \_\_\_\_\_

**REVIEWED BY: FGH CAD MR**

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**MANAGED CARE REFERRAL WAIVER FORM**

As a member of a managed care plan, preferred provider organization and the like, if you visit a specialist before obtaining a referral from your primary care physician (PCP), your insurance will not cover your treatment by the specialist. You will be responsible for all charges for this visit. In some cases, i.e., Blue Choice members, the service you receive today will be covered at an out-of-network benefit level. Please consult your member handbook.

Your signature below indicates that if you receive specialty care services without the consent of your primary care physician, you will assume financial responsibility for such services.

The patient has been informed that there is no referral on file for today's visit and that he/she will assume financial responsibility.

Specialty Care Physician's Name:  
(please circle one)

Dr. DiCecca

Dr. Heller

Dr. Rosen

Name of Office Staff: \_\_\_\_\_ Date: \_\_\_\_\_

I understand that a referral from my PCP is required for today's service and that my insurance company will deny payment for this office visit if a referral is not obtained.

Member's Name: \_\_\_\_\_  
(please print)

Member's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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PREGNANCY QUESTIONNAIRE

THE FOLLOWING INFORMATION IS REQUIRED PRIOR TO ANY RADIOGRAPHIC EXAMINATION FOR THE SAFETY OF THE PATIENT.

Patient Name: \_\_\_\_\_ Present Age: \_\_\_\_\_

Radiographic Procedure: \_\_\_\_\_

Date of Exam: \_\_\_\_\_ Last Menstrual Cycle: \_\_\_\_\_

Pregnancy: Yes \_\_\_\_\_ No \_\_\_\_\_

Confirmed through a physicians' office: Yes \_\_\_\_\_ No \_\_\_\_\_

If an x-ray is done in the second half of the menstrual cycle in women who are sexually active, there is a chance of radiation exposure to the fetus. If there is a possibility that you could be pregnant, you may wish to reschedule your examination until after your menstruation has commenced.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Imaging Personnel Signature

\_\_\_\_\_  
Date