WISSAHICKON ORTHOPAEDIC SPECIALISTS, P.C.

MICHAEL CAVANAUGH, M.D.

STEVEN MARSHALICK, PA-C ISABELLE CLAUSS, PA-C

WELCOME TO THE OFFICE!

YOUR APPOINTMENT IS SCHEDULED ON: _____

PLEASE ARRIVE 10-15 MINUTES AHEAD OF TIME TO COMPLETE PAPERWORK

LOCATION: 1401 BETHLEHEM PIKE FLOURTOWN PA 19031

WE ARE LOCATED AT THE CORNER OF BETHLEHEM PIKE AND WISSAHICKON AVE.

THERE IS NO ENTERANCE ON BETHLEHEM PIKE.

TURN DOWN WISSAHICKON AVE TO ENTER THE PARKING LOT.

IF YOU HAVE HAD ANY VACCINE OR BOOSTER, PLEASE MAKE THE OFFICE AWARE.

BRING WITH YOU:

1. **PHOTO ID & MEDICAL INSURANCE CARDS**
2. **IF INSURANCE REFERRAL IS NEEDED CALL YOUR PRIMARY**
   a. OUR NPI: 1588693683 DIAGNOSIS CODE: R68.89
3. **LIST OF MEDICATION WITH DOSAGE AND FREQUENCY**
4. **ANY DIAGNOSTIC STUDIES** (XRAYS, MRIS, CT SCANS, ETC) **DISC AND REPORTS**

NO REPORT? CALL THE FACILITY WHERE IT WAS DONE AND HAVE IT FAXED TO US

NO DISC? CALL THE FACILITY WHERE IT WAS DONE AND PICK UP BEFORE HAND

IF YOU ARE UNABLE TO KEEP YOUR APPOINTMENT, PLEASE PROVIDE 24 HR NOTICE!

THANK YOU!

1401 BETHLEHEM PIKE ◈ FLOURTOWN PA 19031
PHONE: (215)233-1001 FAX: (215)233-9749

WISSAHICKON ORTHOPAEDIC SPECIALISTS, P.C.

ACCT #: _____

DATE: _____

PATIENT NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ APT/ FL00R: _____

CITY: _____ STATE: _____ ZIP CODE: _____

GENDER: _____ HOME PHONE: _____ CELL PHONE: _____

RACE: _____ ETHNICITY: _____ OCCUPATION: _____

EMAIL ADDRESS: _____

FAMILY DOCTOR: _____ PHONE: _____

MEDICAL INSURANCE: _____ POLICY#: _____

SUBSCRIBER'S NAME: _____ DOB: _____

PRESCRIPTION PLAN: _____ POLICY #: _____

EMERGENCY CONTACT: _____ RELATION: _____ PHONE: _____

PHARMACY NAME: _____ PHONE: _____

REASON FOR VISIT (BODY PART): _____

DATE OF INJURY: _____ LOCATION INJURY OCCUR: _____

HOW DID IT HAPPEN: _____

DID YOU HAVE IMAGING STUDIES DONE? □ NO □ YES IF YES, WHERE? _____

WORKERS COMP OR MOTOR VEHICLE ACCIDENTS INJURIES ONLY

CHECK THE FOLLOWING: □ WORKERS COMP. □ SLIP & FALL □ MOTOR VEHICLE ACCIDENT

DATE OF ACCIDENT: _____ CLAIM #: _____

INSURANCE NAME: _____ PHONE: _____

CLAIM ADJUSTER NAME: _____ PHONE: _____ EXT: _____

ATTORNEY NAME: _____ PHONE: _____

PATIENT SIGNATURE: _____ DATE: _____

WISSAHICKON ORTHOPAEDIC SPECIALISTS, P.C.

ACCT #: _____

PATIENT NAME: _____ DATE: _____

PAST MEDICAL HISTORY: (CHECK ALL THAT APPLY)

- ◻ ANESTHESIA PROBLEMS
- ◻ ARTHRITIS
- ◻ ASTHMA
- ◻ BLOOD CLOTS
- ◻ CANCER – TYPE: _____
- ◻ DIABETES: ◻ TYPE 1 ◻TYPE 2
- ◻ EASY BLEEDING
- ◻ EASY BRUISING
- ◻ FIBROMYALGIA
- ◻ GOUT
- ◻ HEART DISEASE
- ◻ HIGH BLOOD PRESSURE
- ◻ HIGH CHOLESTEROL
- ◻ HIV/ AIDS
- ◻ JOINT REPLACEMENT:
  LOCATION: _____
- ◻ KIDNEY DISEASE
- ◻ LIVER DISEASE
- ◻ LUNG DISEASE
- ◻ LUPUS
- ◻ OTHER: _____
- ◻ LYME DISEASE
- ◻ MULTIPLE SCLEROSIS
- ◻ MUSCULAR DYSTROPHY
- ◻ NEUROPATHY
- ◻ ORGAN TRANSPLANT: _____
- ◻ OSTEOPOROSIS
- ◻ OSTEOPENIA
- ◻ PACEMAKER
- ◻ PARKINSON'S DISEASE
- ◻ PERIPHERAL VASCULAR DISEASE
- ◻ PHLEBITIS
- ◻ PULMONARY EMBOLI
- ◻ RHEUMATOID ARTHRITIS
- ◻ SEIZURE DISORDER
- ◻ SICKLE CELL DISEASE
- ◻ SICKLE CELL TRAIT
- ◻ STOMACH ULCERS
- ◻ STROKE
- ◻ THYRIOD DISEASE ◻ HYPO ◻ HYPER
- ◻ TUBERCULOSIS

ARE YOU PREGNANT? ◻ YES ◻ NO

DID YOU HAD COVID-19 VACCINE? ◻ NO ◻ YES, DATES: _____

PAST SURGICAL HISTORY (LIST ALL MAJOR SURGERIES & DATES IF KNOWN) ◻ NO SURGERIES

_____

_____

_____

_____

ALLERGIES: ◻ NO KNOWN DRUG OR OTHER ALLERGIES ◻ YES (PLEASE LIST BELOW)

_____

_____

PLEASE CONTINUE ON BACK SIDE!

PATIENT NAME: _____ ACCT #: _____

MEDICATION LIST: (PRESCRIPTION & OVER THE COUNTER DRUGS) ☐ SEE ATTACHED LIST

NAME OF MEDICATION	DOSE & FREQUENCY	REASON

FAMILY HISTORY: (CHECK ALL THAT APPLY) ☐ NONE ☐ UNKNOWN

☐ BLOOD DISORDER ☐ CANCER- TYPE: _____

☐ DIABETES ☐ HEART DISEASE ☐ HYPERTENSION ☐ KIDNEY DISEASE

☐ OSTEOPOROSIS ☐ RHEUMATOID ARTHRITIS ☐ HEART ATTACK ☐ STROKE

☐ OTHER: _____

SOCIAL HISTORY: (CHECK ALL THAT APPLY)

DO YOU WEAR GLASSES OR CONTACTS? ☐ NO ☐ GLASSES ☐ CONTACT LENSES

DOMINANT HAND: ☐ RIGHT ☐ LEFT ☐ AMBIDEXTROUS.

TOBACCO USE: ☐ NEVER ☐ FORMER: WHEN DID YOU QUIT? _____

☐ CURRENT SMOKER: TYPE: _____ OFTEN: _____

ALCOHOL USE: ☐ NEVER ☐ OCCASIONALLY ☐ _____ # OF DRINKS PER _____

CAFFEINE USE: (DAILY BASIS) ☐ NONE ☐ OCCASIONALLY

☐ TYPES: _____ #TIMES PER DAY _____

PATIENT NAME: _____ ACCT #: _____

REVIEW OF SYSTEMS: (CHECK ALL THAT APPLY TO YOUR CHIEF COMPLAINT)

GENERAL: □ NO PROBLEM
□ UNEXPECTED WEIGHT LOSS □ UNEXPECTED WEIGHT GAIN
□ CHILLS □ FEVER □ FATIGUE

EYE: □ NO PROBLEM
□ DOUBLE VISION □ BLURRED VISION □ EYE PAIN
□ REDNESS □ WATERING □ VISUAL DISTURBANCE

EARS, NOSE, & THROAT: □ NO PROBLEM □ EARACHE
□ DIFFICULTY SWALLOWING □ NOSE BLEEDS □ RINGING IN EARS

CARDIOVASCULAR: □ NO PROBLEM
□ CHEST PAIN □ PALPITATIONS □ MURMERS □ FAINTNESS

RESPIRATORY: □ NO PROBLEM □ CHEST PAIN W/ INSPIRATION
□ SHORTNESS OF BREATH □ TIGHTNESS □ WHEEZING
□ PAIN ON BREATHING IN □ COUGHING □ SNORING

INTESTINAL: □ NO PROBLEM
□ HEARTBURN □ DIARRHEA □ CONSTIPATION □ NAUSEA
□ VOMITING □ BLOODY STOOL □ TARRY/BLACK STOOLS

URINARY: □ NO PROBLEM □ DIFFICULTY VOIDING □ FLANK PAIN
□ URINE FREQUENCY □ URINE URGENCY □ PAINFUL URINE
□ BLOOD IN URINE □ DIFFICULTLY STARTING OR STOPPING URINATION

MUSCULOSKETAL: □ NO PROBLEM
□ JOINT PAIN □ REDNESS □ SWELLING □ INSTABILITY
□ HEAT □ MUSCLE PAIN □ STIFFNESS

SKIN: □ NO PROBLEM □ URTICARIA
□ SKIN CHANGES □ ITCHING □ REDNESS □ RASH □ WOUND

NEURO: □ NO PROBLEM □ INCOORINATION □NUMBESS/TINGLING
□ DIZZINESS □UNSTEADY GAIT □ HEADACHES □ TREMOR/SEIZURES

PSYCHIATRIC: □ NO PROBLEM
□ ANXIETY □ DEPRESSION □ NERVOUSNESS □ HALLUCINATIONS

HEMATOLOGIC: □ NO PROBLEM
□ EASY BLEEDING □ EASY BRUISING □ CLOTS

ENDOCRINE: □ NO PROBLEM
□ HEAT\COLD INTOLERANCE □ EXCESSIVE THIRST □ EXCESSIVE URINATION

FOR PATIENTS 65 YEAR OR OLDER

DO YOU USE ANY WALKING DEVICES? □ CANE	□ WALKER □ WHEELCHAIR	□ NONE
DO TAKE ANY BLOOD THINNERS?	□ YES	□ NO
DO YOU HAVE A PACEMAKER?	□ YES, DATE: _____	□ NO
DO YOU EXERCISE ON A REGULAR BASIS?	□ YES	□ NO
DO YOU HAVE ADVANCED DIRECTIVES?	□ YES	□ NO
DID YOU HAVE A PNEUMONIA VACCINE?	□ YES, DATE: _____	□ NO
DID YOU HAVE A FLU VACCINE?	□ YES, DATE: _____	□ NO
DID YOU HAVE A BONE DENSITY SCAN?	□ YES, DATE: _____	□ NO

PATIENT NAME: ____ ACCT #: ______________________

STAFF USE ONLY

DATE: ____________________	**TEMP: ______________ B/P: _________________**
INITIALS: __________________	**HEIGHT: ____________ WEIGHT: ____________**
DATE: ____________________	**TEMP: ______________ B/P: _________________**
INITIALS: __________________	**HEIGHT: ____________ WEIGHT: ____________**
DATE: ____________________	**TEMP: ______________ B/P: _________________**
INITIALS: __________________	**HEIGHT: ____________ WEIGHT: ____________**

DATE: ____________________	**TEMP: ______________ B/P: _________________**
INITIALS: __________________	**HEIGHT: ____________ WEIGHT: ____________**
DATE: ____________________	**TEMP: ______________ B/P: _________________**
INITIALS: __________________	**HEIGHT: ____________ WEIGHT: ____________**
DATE: ____________________	**TEMP: ______________ B/P: _________________**
INITIALS: __________________	**HEIGHT: ____________ WEIGHT: ____________**

DATE: ____________________	**TEMP: ______________ B/P: _________________**
INITIALS: __________________	**HEIGHT: ____________ WEIGHT: ____________**
DATE: ____________________	**TEMP: ______________ B/P: _________________**
INITIALS: __________________	**HEIGHT: ____________ WEIGHT: ____________**
DATE: ____________________	**TEMP: ______________ B/P: _________________**
INITIALS: __________________	**HEIGHT: ____________ WEIGHT: ____________**

WISSAHICKON ORTHOPAEDIC SPECIALISTS, P.C.

ACCT #: _____

FINANCIAL POLICY & OFFICE REGULATIONS

THANK YOU FOR CHOOSING US AS YOUR ORTHOPAEDIC SPECIALIST. WE ARE COMMITTED TO PROVIDING YOU THE BEST POSSIBLE CARE & ARE PLEASED TO DISCUSS OUR PROFESSIONAL FEES WITH YOU AT ANY TIME. PLEASE READ AND SIGN ACKNOWLEDGING THE REGULATIONS.

CO-PAY: WE ARE A SPECIALTY OFFICE; THEREFORE, YOUR CO-PAY MAY BE HIGHER. PLEASE CONTACT YOUR INSURANCE COMPANY FOR YOUR SPECIALIST CO-PAY AMOUNT.

ALL CO PAYS AND OUTSTANDING BALANCES WILL BE COLLECTED UPON CHECKING IN FOR YOUR SCHEDULED APPOINTMENT. WE ACCEPT CASH, PERSONAL CHECKS, VISA, MASTERCARD, DISCOVER AND AMEX.

INSURANCE: WE WILL SUBMIT A CLAIM TO THE INSURANCE COMPANY FOR WHICH YOU HAVE PROVIDED THE INFORMATION. IN INJURY CASE WE REQUIRE MEDICAL PRIMARY AND SECONDARY INSURANCE AS WELL AS ANY CHANGE OF INSURANCE. IF CLAIMS ARE DENIED BY YOUR INSURANCE COMPANY, YOU WILL BE RESPONSIBLE FOR PAYMENT IN FULL.

FAILURE TO PROVIDE COMPLETE INSURANCE INFORMATION MAY RESULT IN THE BILL BEING CHARGED DIRECTLY TO YOU.

UNINSURED PATIENTS: IF YOUR INSURANCE COMPANY IS NOT CONTRACTED WITH US, YOU AGREE TO PAY FOR ANY PORTION OF THE CHARGES NOT COVERED BY INSURANCE. THE ACTUAL BALANCE WILL NOT BE KNOWN UNTIL TREATMENT HAS BEEN PERFORMED AND COMPLETED.

YOU ARE RESPONSIBLE FOR THE ACTUAL CHARGES AND NOT THE ESTIMATED FEES. PAYMENT IS DUE AT TIME OF SERVICE.

MINOR PATIENTS: THE ADULT PARENT OR GUARDIAN ACCOMPANYING THE MINOR IS RESPONSIBLE FOR THE PAYMENT OF THE MINOR PATIENT'S ACCOUNT REGARDLESS OF WHO THE INSURANCE POLICY HOLDER IS. FOR UNACCOMPANIED MINORS NON-EMERGENCY TREATMENT CAN BE DENIED UNTIL A PARENT OR GUARDIAN IS PRESENT OR WE HAVE WRITTEN PERMISSION FOR TREATMENT.

FOR MINORS: PATIENT'S GUARDIAN WILL BE FINANCIALLY RESPONSIBLE FOR PATIENTS' ACCOUNT.

MISSED APPOINTMENTS: FAILURE TO GIVE 24-HOUR NOTICE OF CANCELLATION OF YOUR APPOINTMENT WILL RESULT IN A $25.00 FEE. WE WILL NOT BILL YOUR INSURANCE COMPANY; THIS WILL BE YOUR RESPONSIBLE FOR PAYMENT.

FAILURE TO GIVE 24-HOUR CANCELATION NOTICE WILL RESULT IN A $25.00 CANCELATION FEE.

DELINQUENT ACCOUNTS: IF YOUR ACCOUNT BECOMES PAST DUE YOU WILL RECEIVE A COLLECTION WARNING FROM US. IF RECEIVED PLEASE CONTACT THE OFFICE AS SOON AS POSSIBLE. OUR STAFF CAN ASSIST YOU TO SET-UP PAYMENT ARRANGEMENTS. FINANCE FEES WILL BE ADDED FOR COLLECTION ACCOUNTS. AFTER (90) DAYS, YOUR ACCOUNT WILL BE REVIEWED TO SUBMIT TO THE COLLECTION AGENCY.

ONCE ACCOUNT IS PLACED IN THE OUTSIDE COLLECTION AGENCY ARE DISCHARGED FROM ANY FUTURE SERVICES OR TREATMENT.

HIPAA PRIVACY POLICY: I UNDERSTAND THAT, UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1998 (HIPAA), I HAVE CERTAIN RIGHTS TO PRIVACY REGARDING MY PROTECTED HEALTH INFORMATION. I UNDERSTAND THAT THIS INFORMATION CAN AND WILL BE USED TO CONDUCT, PLAN AND DIRECT MY TREATMENT AND FOLLOW UP AMONG THE MULTIPLE HEALTHCARE PROVIDERS WHO MAY BE INVOLVED IN THAT TREATMENT DIRECTLY AND INDIRECTLY.

COPIES OF THE HIPAA PRIVACY POLICY ARE MADE AVAILABLE AT THE FRONT DESK.

PLEASE SIGN BELOW AFTER YOU HAVE READ AND ACKNOWLEDGED THE ABOVE REGULATIONS.

PATIENT NAME: (PRINT) _____ **DATE OF BIRTH: _____**

PATIENT SIGNATURE: _____ **DATE SIGNED: _____**