Orthopaedic & Spine Surgery Institute
19450 Deerfield Ave, Suite 275
Lansdowne, VA 20176
www.OSSI-Virginia.com

Ali Moshirfar, M.D.
George Ibrahim, M.D.
Meredith Soriano, NP-C
703-723-OSSI (6774)

PATIENT INFORMATION

Last Name: ______________________ **First Name:** ______________________ **Date:** __________

Preferred Name: ______________________ **Date of Birth:** ______________ **Age:** ______ **Sex:** ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed **Best Phone #:** ______________________ ☐ H ☐ M ☐ W

Home Address: ______________________ **City:** ______________ **State:** ______ **Zip:** __________

Are you currently residing in a nursing facility? ☐ Yes ☐ No **Name/ Address of facility?** ______________________

Email Address: ______________________

Preferred Pharmacy (Name & Location): ______________________

Race: ☐ African American ☐ Asian ☐ White/ Caucasian ☐ Other ☐ Decline to Respond

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Respond

Employer Name: ______________________ **Occupation:** ______________________

Primary Care Physician: ______________________ **Phone #:** ______________________

Referring Physician: ______________________ **Phone #:** ______________________

Emergency Contact: ______________________ **Relationship:** ______________ **Phone #:** ______________

Same address as yourself? ☐ Yes ☐ No **HIPPA Contact:** ☐ Yes ☐ No

INSURANCE INFORMATION

Primary Insurance Company: ______________________ **Claims Phone #:** ______________

Claims Address: ______________________ **City:** ______________ **State:** ______ **Zip:** __________

Subscriber's Name: ______________________ **Date of Birth:** ______________ **Relationship:** __________

Policy/ Member #: ______________________ **Group #:** ______________________

Secondary Insurance Company: ______________________ **Claims Phone #:** ______________

Claims Address: ______________________ **City:** ______________ **State:** ______ **Zip:** __________

Subscriber's Name: ______________________ **Date of Birth:** ______________ **Relationship:** __________

Policy/ Member #: ______________________ **Group #:** ______________________

WORKMAN'S COMPENSATION

Date of Injury: ______________ **State where injury occurred:** __________

Worker's Comp Insurance Company: ______________________ **Claim #:** ______________

Insurance Address: ______________________ **City:** ______________ **State:** ______ **Zip:** __________

W/C Contact Person: ______________________ **Phone #:** ______________________

W/C Case Manager: ______________________ **Phone #:** ______________________

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AUTHORIZATION FOR CLAIMS AND PAYMENTS

I hereby authorize **Orthopaedic & Spine Surgery Institute** to apply for benefits on my behalf. I request that payment for covered services is made directly to **Orthopaedic & Spine Surgery Institute** unless it indicates otherwise. I certify that the information I have provided about my insurance coverage is correct and further authorize the release of information, medical and other, as necessary in the processing of claims. I acknowledge and understand that I am responsible for the payment of all services rendered to me or any member of my family.

Should any employee or other individual be exposed to my blood or bodily fluids, I hereby consent to testing my blood for Hepatitis virus and AIDS (HIV) virus as necessary.

I hereby certify that the information I have provided is true and correct to the best of my ability.

YOUR SIGNTURE BELOW constitutes that you fully understand, acknowledge, and agree with the above policies of **Orthopaedic & Spine Surgery Institute**.

Patient or Guarantor Signature: ______________________________ **Date:** ____________

Patient or Guarantor Printed Name: ______________________________ **Relationship to Patient:** ____________

CANCELLATION POLICY

Orthopaedic & Spine Surgery Institute requires 24-hour advance notice for cancelled appointments and/or procedures. Our receptionists are available from 8:30 am to 4:30 pm Monday through Friday to accept your calls to cancel or reschedule appointments. You may also cancel appointments by sending a message through the patient portal.

Any appointment or procedure that is not canceled within a 24 hours' notice will be subject to a cancelation fee as follows:

OFFICE VISIT: $35.00

PROCEDURE VISIT: Will vary based on location and procedure type

The cancelation fee is the responsibility of the patient/ guarantor and will not be billed to your insurance company.

YOUR SIGNTURE BELOW constitutes that you fully understand, acknowledge, and agree with the above policies of **Orthopaedic & Spine Surgery Institute**.

Patient or Guarantor Signature: ______________________________ **Date:** ____________

HIPAA AND PATIENT PRIVACY PRACTICES

I hereby give my consent to **Orthopaedic & Spine Surgery Institute** to use and disclose my protected health information (PHI) to carry out treatment, payment, and health care operations (TPO). This may include releasing information to other medical providers for continued treatment. The Notice of Privacy Practices provided by Loudoun Medical Group describes such uses and disclosures more completely and can be accessed online at https://www.lmgdoctors.com/wp-content/uploads/2018/10/Notice-of-Privacy.pdf. I understand I have the right to review these notices prior to signing this consent.

Orthopaedic & Spine Surgery Institute reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to this office.

By signing this form, I am consenting to allow **Orthopaedic & Spine Surgery Institute** to use and disclose my PHI to carry out TPO. I understand that this consent also grants permission to view my medical and prescription history from external sources. I understand that I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **Orthopaedic & Spine Surgery Institute** may decline to provide treatment.

Orthopaedic & Spine Surgery Institute may contact me via phone, email, or my mailing address regarding my diagnosis, results, payments, or treatment and care. I may request any other means of communication, or I may deny a particular means of communication in writing.

Patient or Guarantor Signature: ______________________________ **Date:** ____________

The following person(s) may receive information out me and my healthcare:

Name: ____________________ **Relationship:** ____________ **Phone #:** ____________

Name: ____________________ **Relationship:** ____________ **Phone #:** ____________

*** The above-named person(s) will remain in effect until changes are received in writing. ***

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GENERAL MEDICAL INFORMATION

Last Name: ______________________ **First Name:** ______________________ **DOB:** ____________

Height: __________ **Weight:** __________ **Age:** __________ **Sex:** ☐ Male ☐ Female

History of Present Illness or Injury

Date of Injury/Onset: ______________ Secondary to ☐ Accident ☐ Chronic ☐ Illness ☐ Work ☐ Other

What is the present problem? ____

____

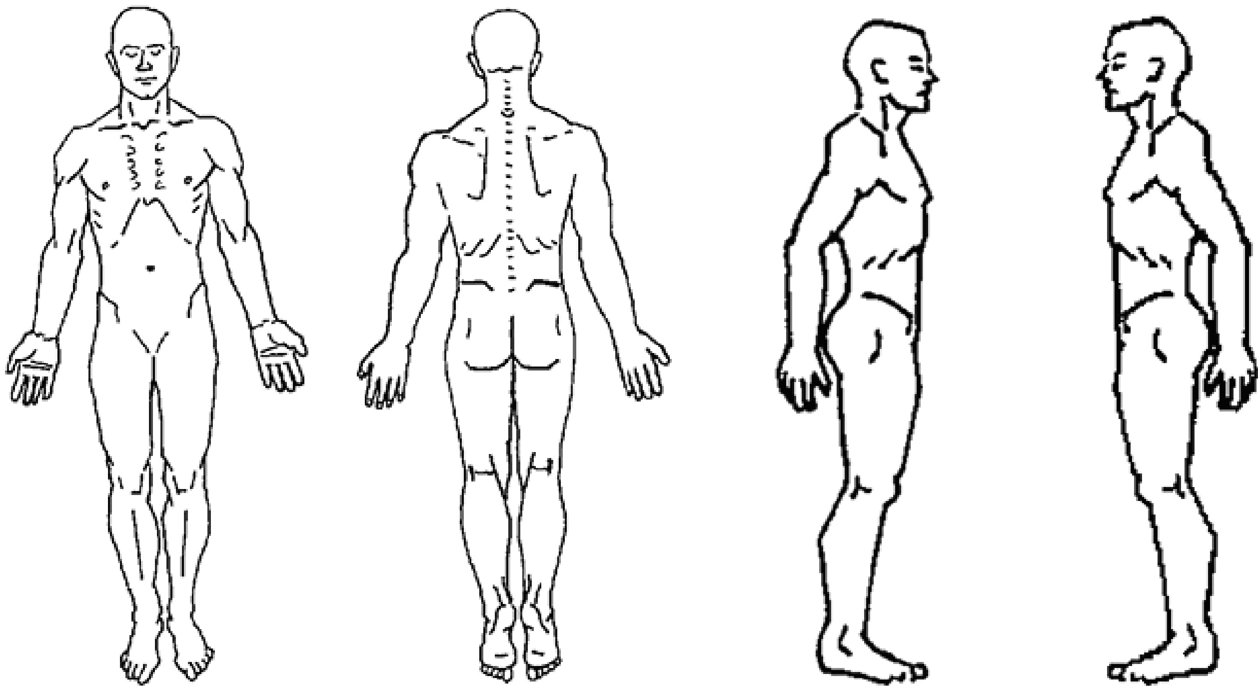
Describe how the injury occurred (BE SPECIFIC): ____

____

____

Location and Details of Pain/ Complaint

Please use the legend below to mark the figures below by adding the letter(s) that correspond to the type of pain you are experiencing.



Where is the worst pain out of 100%?

Neck Pain ________% VS Arm Pain ________%
Back Pain ________% VS Leg Pain ________%

TYPE OF PAIN	SYMBOL
Aching	AAA
Burning	BBB
Numbness	NNN
Pins/Needles	PPP
Stabbing	SSS

*Mark figures with letters

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How often do you experience this pain/ complaint? ☐ Constantly ☐ Intermittently ☐ Episodic (irregularly)

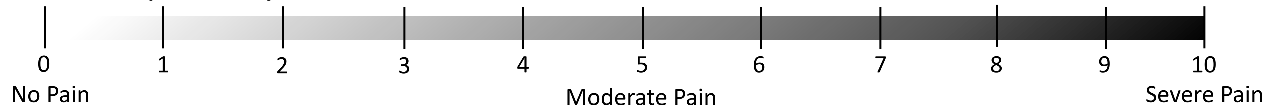
How long have you been experiencing this pain/ complaint? _______ Years _______ Months _______ Weeks _______ Days

Please describe your pain: ☐ Dull ☐ Ache ☐ Sharp ☐ Shooting ☐ Burning ☐ Stabbing ☐ Tingling ☐ Throbbing

When do you experience this pain/ complaint? ☐ Morning ☐ Evening ☐ Night
☐ Exercising ☐ Laying down ☐ Sitting ☐ Standing ☐ Walking

How unbearable is the pain when you are without activity (inactive)?

How unbearable is the pain when you are active?



Indicate how your symptoms respond to the following.

Standing	☐ Relieves	☐ Worsens	☐ No Difference
Sitting	☐ Relieves	☐ Worsens	☐ No Difference
Lying Down	☐ Relieves	☐ Worsens	☐ No Difference
Stretching/Exercise	☐ Relieves	☐ Worsens	☐ No Difference

Other (please specify): ______________________________

What treatment(s) have you tried thus far and how much relief have you received from them?

Medication	☐ Excellent Relief	☐ Moderate Relief	☐ No Relief	☐ Have not tried
Heat/Ice	☐ Excellent Relief	☐ Moderate Relief	☐ No Relief	☐ Have not tried
Physical Therapy	☐ Excellent Relief	☐ Moderate Relief	☐ No Relief	☐ Have not tried
Injections	☐ Excellent Relief	☐ Moderate Relief	☐ No Relief	☐ Have not tried
Chiropractor	☐ Excellent Relief	☐ Moderate Relief	☐ No Relief	☐ Have not tried

If you have had injections or other procedures, please list them below (e.g., joint injections, epidural, facet injections, nerve root injections, stimulators, or nerve ablations). ______________________________

____

____

Please list any health care professional that has treated this specific problem in the past and the treatment that was rendered.

Primary Care Name:	____________________	**Treatment:**	____________________
Physical Therapy Name:	____________________	**Treatment:**	____________________
Pain Management Name:	____________________	**Treatment:**	____________________
Chiropractor Name:	____________________	**Treatment:**	____________________
Other:	____________________	**Treatment:**	____________________

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Past Medical History

Check ALL that apply:

☐ Arthritis	☐ Diabetes	☐ Kidney Failure	☐ Sinusitis
☐ Asthma	☐ Diverticulitis	☐ Kidney Stones	☐ Stomach Ulcers
☐ Back Pain	☐ Emphysema (COPD)	☐ Liver Disease	☐ Stroke
☐ Bleeding Disorders	☐ Fibromyalgia	☐ Neck Pain	☐ Thyroid Disease
☐ Bronchitis	☐ HIV	☐ Osteoporosis	☐ Tumors/Cancers
☐ Crohn's Disease	☐ Heart Attack	☐ Pancreatitis	☐ Tuberculosis
☐ CHF	☐ Heart Murmurs	☐ Reflux (GERD)	☐ Ulcerative Colitis
☐ Blood Clots (DVT)	☐ Hepatitis	☐ Rheumatoid Arthritis	☐ Vascular Disease
☐ Depression	☐ Hypertension	☐ Seizures	

Other: ____

Past Surgical History: ____

____

____

Hospitalizations (past 2 years only): ____

____

____

Medications (name, dosage, frequency). Please include over the counter medications, vitamins, supplements, and topical creams/lotions. If necessary, please attach a separate sheet.

______________________ ______________________

______________________ ______________________

______________________ ______________________

Allergies (name of allergen, reaction, and how treated). ☐ NO KNOWN DRUG ALLERGIES

______________________ ______________________

______________________ ______________________

Family History

Check ALL that apply:

☐ Arthritis	☐ Diabetes	☐ Kidney Failure	☐ Sinusitis
☐ Asthma	☐ Diverticulitis	☐ Kidney Stones	☐ Stomach Ulcers
☐ Back Pain	☐ Emphysema (COPD)	☐ Liver Disease	☐ Stroke
☐ Bleeding Disorders	☐ Fibromyalgia	☐ Neck Pain	☐ Thyroid Disease
☐ Bronchitis	☐ HIV	☐ Osteoporosis	☐ Tumors/Cancers
☐ Crohn's Disease	☐ Heart Attack	☐ Pancreatitis	☐ Tuberculosis
☐ CHF	☐ Heart Murmurs	☐ Reflux (GERD)	☐ Ulcerative Colitis
☐ Blood Clots (DVT)	☐ Hepatitis	☐ Rheumatoid Arthritis	☐ Vascular Disease
☐ Depression	☐ Hypertension	☐ Seizures	

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Social History

Occupation: ____ **Years present at job:** ______________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Tobacco Use: ☐ Never Smoked ☐ Former Smoker ☐ Current Smoker ☐ Smokeless Tobacco

Alcohol Use: ☐ Yes ☐ No **How much alcohol per day?** ___________ **Have you ever abused alcohol?** ☐ Yes ☐ No

Drug Use: ☐ Yes ☐ No **Have you ever used drugs in the past?** ☐ Yes ☐ No

Are you currently involved in any litigation or lawsuit relation to your injury/complaint? ☐ Yes ☐ No

Review of Symptoms

Check ALL that apply and are *recent* symptoms:

General:	☐ Change in weight ☐ Appetite ☐ Sleep ☐ Taste/Smell ☐ Fatigue ☐ Fever
Skin:	☐ Rash ☐ Itching
Head & Neck:	☐ Dizziness ☐ Balance Problems ☐ Vision/Eye Problems ☐ Hoarseness ☐ Trouble Swallowing
Pulmonary:	☐ Chronic Cough ☐ Emphysema ☐ Tuberculosis ☐ Bronchitis
Cardiovascular:	☐ High Blood Pressure ☐ Chest Pain ☐ Heart Attack ☐ Shortness of Breath ☐ Blood Clots (DVT)
Gastrointestinal:	☐ Stomach Ulcers ☐ Stomach Bleed(s) ☐ Heartburn ☐ Diarrhea ☐ Constipation
Urinary:	☐ Kidney Stones ☐ Kidney Infection(s) ☐ Painful Urination ☐ Incontinence ☐ Bleeding
Reproductive:	☐ Sexually Transmitted Diseases ☐ Bleeding ☐ Impotence
Hematologic/Lymphatic:	☐ HIV or AIDS ☐ Lymphoma ☐ Bleeding Problems ☐ Skin Cell Disease
Musculoskeletal:	☐ Osteoarthritis ☐ Rheumatoid Arthritis ☐ Back Pain ☐ Neck Pain ☐ Joint Pain ☐ Muscle Disorder
Neurological:	☐ Fainting ☐ Headache ☐ Seizure ☐ Memory ☐ Dizziness ☐ Numbness

To the best of my knowledge and ability the information I have provided is true and complete.

Patient or Guarantor Signature: ________________________________ **Date:** ____________

Patient or Guarantor Printed Name: ________________________ **Relationship to Patient:** ____________

CC (Staff Use Only): ____