



**CAPITOL ORTHOPAEDICS & REHABILITATION, LLC**

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**FILL OUT THIS FORM (mostly) ON-LINE & then Print it. Manually Complete and SIGN.**  
 Fax to 301 770 7904 or bring to the office

|                                 |                                 |                  |
|---------------------------------|---------------------------------|------------------|
| <b>Account Number:</b><br>_____ | <b>PATIENT INFORMATION FORM</b> | . Dr. _____<br>. |
|---------------------------------|---------------------------------|------------------|

Please Type in this Form!

\* Last Name ..... \* First Name ..... \* Middle .. \* ..Sex ... \* ..Age ..... \* Marital Status

\* Street Address ..... \* Apt.# ... \* City ..... \* State ... \* Zip

\* Home Phone ..... \* SS# ..... \* Date of Birth ..... \* Cell Phone ...

\* Name of Employer ..... \* Occupation ..... \* Work Phone ..... \* Email. ....

Referred by: \_\_\_\_\_

**MEDICAL INSURANCE INFORMATION**

\* Primary Company ..... \* Identification No. .... \* Group No. .... \* Subscriber / Relationship to Patient

\* Subscriber's Name ..... \* Employer ..... \* Work Phone # .....

\*\* Subscriber's Date of Birth ... \* S.S. # .....

\* Secondary Company ... \* Identification No. ... \* Group No. ... \* Subscriber. ... / Relationship to Patient

\* Subscriber's Name ... \* Employer ... \* Work Phone #

\*\* Subscriber's Date of Birth ... \* S.S. #

**MEDICAL INFORMATION**

Reason for visit: \_\_\_\_\_

Date of onset of symptoms or injury \_\_\_\_\_

If an injury, what was the cause? \_\_\_\_\_ work \_\_\_\_\_ auto \_\_\_\_\_ sports \_\_\_\_\_ other

If auto accident: State it occurred in? \_\_\_\_\_

Family physician \_\_\_\_\_ Is this a second opinion? \_\_\_\_\_ Yes \_\_\_\_\_ No

Allergies to medications \_\_\_\_\_

**METHOD OF PAYMENT**

\_\_\_\_\_ Cash \_\_\_\_\_ Check \_\_\_\_\_ Credit Card

**I certify that the information I have reported with regard to my insurance coverage is correct and I authorize the release of any information, including medical information for this or any related claim to**

\_\_\_\_\_ ( Name of Insurance Carrier)

**I permit a copy of this authorization to be used in place of the original.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

**I, \_\_\_\_\_, hereby authorize CAPITOL ORTHOPAEDICS & REHABILITATION, LLC or Marc Grossman, MD PC to apply for benefits on my behalf for covered services rendered by my doctor or therapist from the belowmentioned insurance company, and promise to pay all outstanding amounts as determined by insurance company. I agree to pay all reasonable interest charges, collection fees and attorney fees in relation to the collection of these amounts. I agree to pay for "no-show" fees, as described by the office.**

\_\_\_\_\_ ( Name of Insurance Carrier)

**Signature \_\_\_\_\_ Date \_\_\_\_\_**

**MEDICARE LIFETIME AUTHORIZATION**

**"I request that payment of authorized Medicare benefits be made either to me or on my behalf to CAPITOL ORTHOPAEDICS & REHABILITATION, LLC, Marc Grossman, MD, PC for any services furnished me by that physician or supplier. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services. "**

Signature \_\_\_\_\_ Date \_\_\_\_\_

Medicare I. D. Number \_\_\_\_\_