Atlantic General Surgery Associates, LLC

Adam J. Schechner, MD

General and Trauma Surgery

Patient's Name: Last _____ First _____ MI _____
Date of Birth _____ Age _____ Gender _____ Marital status _____
SSN _____
Address _____
Street City State Zip
Home Phone _____ Work _____ Cell _____
Employer _____ Occupation _____
Spouse/Parent's name _____
Spouse/Parent's employer _____ Occupation _____
Emergency contact, relationship, phone number _____

IS THIS CONDITION/INJURY RELATED TO WORK _ If yes, date and location of injury _____
Reported to supervisor? __ Name of Supervisory _____ Phone number _____
How were you injured? _____
Claim# _____ Adjuster _____ Phone number _____

Primary Insurance name _____ Policy #_____ Group # _____
Address _____
Street City State Zip
Subscriber's name _____ Subscriber's Date of Birth _____

Secondary Insurance name _____ Policy #_____ Group # _____
Address _____
Street City State Zip
Subscriber's name _____ Subscriber's Date of Birth _____

IS THIS CONDITION ACCIDENT-RELATED? _____ Were you at fault? _____
IS THERE A LAWYER HANDLING YOUR CASE? __
Lawyer's name _____ Phone number _____
Address _____
Street City State Zip
Name of Primary Physician _____ Phone number _____
Referred by _____

AUTHORIZATION: I understand that I am financially responsible for all charges, whether or not they are covered by my insurance company.

ASSIGNMENT: I permit and authorize payment directly to Atlantic General Surgery Associates, LLC for any benefits due for services rendered.

MEDICAL RECORDS: Authorization is hereby granted for release of any information required to process this claim. A copy of this authorization is as valid as the original.

MEDICARE PATIENTS: I request that payment of authorized medical benefits be made to Atlantic General Surgery Associates, LLC for any services furnished me by physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.
PATIENT'S SIGNATURE: _____ **DATE:** _____

FOR SECONDARY INSURANCE: I request that payment of authorized medical benefits be made to Atlantic General Surgery Associates, LLC for any services furnished me by physician or supplier.
PATIENT'S SIGNATURE: _____ **DATE:** _____

I hereby declare that the Notice of Privacy Practices has been made available to me.
PATIENT'S SIGNATURE: _____ **DATE:** _____

Phone: 301-493-4826 | Fax: 301-493-4828 | 5602B Shields Dr, Bethesda, MD 20817

Atlantic General Surgery Associates, LLC
Adam J. Schechner, MD
General and Trauma Surgery

Patient History Questionnaire

Name: _____ Date: _____
Reason for visit: _____

Marital status (circle): Single Married Divorced Widowed

Medical History (circle): Hypertension Heart disease Diabetes Stroke
Cancer _____ Thyroid disease Asthma COPD
Other _____

Surgeries: _____

Medications and dosage: _____
_____
_____
_____

Allergies to medicine/latex: _____

Women only: Age of first period: _____ Last period: _____ # of pregnancies: _____

Family history: _____

Do you smoke? _____ How much? _____ Alcohol? _____ Illicit drugs? _____

Do you have problems with:

Neuro/psych: _____
Chest pain: _____
Thyroid: _____
Liver: _____

Eyes, ears, nose, throat: _____
Shortness of breath: _____
Weight loss/gain: _____
Irregular heart beat: _____

Bloody stools: _____
Diahrrea/constipation: _____
Nausea/abdominal pain: _____
Back/neck pain: _____

Phone: 301-493-4826 | Fax: 301-493-4828 | 5602B Shields Dr, Bethesda, MD 20817