

Medical Assistant/Medical Receptionist/Insurance Biller/Office Manager

Name: Date: Experience Since:

Are you certified? Yes No Certified by:

	Comfortable With	Done Occasionally	No Experience
Administrative Duties			
Phones/Messages	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Data Entry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Word Processing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insurance Coding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dictaphone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pegboard	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Collections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Billing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PPO's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HMO's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medicare	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Worker's Compensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Software:

CPT Med. Manager Typing (WPM)
 ICD9 WordPerfect
 CCSI Windows Other(s)

Clinical Duties	Comfortable With	Done Occasionally	No Experience
Patient Prep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vital Signs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adult Injections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pediatric Injections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Phlebotomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EKG's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flex Sigmoidoscopy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulmonary Functions Tests	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lab Tests	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urinalysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pregnancy Tests	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Instrument Familiarity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sterile Technique	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assist Minor Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Name: Date:

What types of office(s) have you worked in before?

1.
2.
3.
4.
5.
6.

Signature

Date

Agency Representative Signature

Date