Excel Physicians

How did you hear about us? (Circle one)
Insurance Yellow Pages Mailer Newspaper Ad Friend Former Bristol Park Patient

Name_____

Address_____

City_____ State_____ Zip Code_____

Home Phone_____ Sex_____ Birth Date_____

Work Phone_____ D.L.#_____

Social Security No._____ Age_____

Occupation_____ Employer_____ Marital Status S/M/D/W

Name of friend or relative not living with you_____ Phone No._____

Primary Ins. No._____ Insured's Name_____

Insurance Co. Name & Address_____

Insured's Birth Date_____ Relationship to Patient_____

Subscriber No._____ Group No._____

Effective Date_____ Co-Payment Amount $_____

Insured's Work No._____

Do you have another insurance? PPO/ HMO/ POS Insured's Name_____

Subscribat No._____ Group No._____ Effective Date_____

If Patient is a minor or Student:

Given Mother's Name_____ Home Phone_____

Home address_____

Occupation_____ Employer_____

Work No._____

Given Father's Name_____ Home Phone_____

Home address_____

Occupation_____ Employer_____

Work No._____

Please note: If there is any question regarding the bill, the person who is registering today will be responsible for payment. If patient is a minor, the person registering for the patient will be responsible.

Release statement:

1. I authorize EXCEL PHYSICIANS and their staff to perform diagnostic tests and provide treatment necessary
2. I accept responsibility for all charges incurred in the medical evaluation and health care of the above named patient.

Signed_____ Date_____

Relationship to patient_____

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Adult Health Inventory

Name_____ Date of Birth_____ MALE/FEMALE

Occupation_____ Age_____ Place of Birth_____

Highest level of education_____

Do you have an advance directive (Living Will/Power of Attorney)? Y / N

If yes, Please give us a copy. If no, would you like information? Y / N

Please list next of kin_____

Please list today's symptoms_____ Routine Physical? Y / N

FAMILY HISTORY

Have you or any blood relative ever had the following: If yes, please list relation

- ☐ Diabetes_____
- ☐ Kidney Disease_____
- ☐ Heart Disease_____
- ☐ High Cholesterol_____
- ☐ High Blood Pressure_____
- ☐ Convulsions/Epilepsy_____
- ☐ Neurological Disease_____
- ☐ Stroke_____
- ☐ Psychiatric Disease_____
- ☐ Suicide_____
- ☐ Allergies_____
- ☐ Tuberculosis_____
- ☐ Cancer_____
- ☐ Thyroid Disease_____
- ☐ Blood Abnormalities_____
- ☐ Other Hereditary Disease_____

PERSONAL HISTORY

Are you allergic to: Penicillin Y / N Sulfa Y / N Any foods? Y / N Iodine/ Shellfish? Y / N

Adhesive Tape? Y / N Cosmetics? Y / N Tetanus Antitoxin or Serums? Y / N

Please list any other drug allergies/adverse reactions to medications_____

Please list all medication you are currently taking_____

Please list all over-the-counter medication you are taking_____

Please list all vitamins or minerals you are taking_____

Date of last:

Physical Examination_____ Mammogram_____

Tetanus immunization_____ Rectal Exam_____

MMR (Measles) Immunization_____ Pap Smear_____

EKG_____ PSA(prostrate)_____

Cholesterol Screen_____

HABITS:

Consume alcoholic beverages? Never Rarely Moderate Daily

Have you ever been treated for alcoholism? Y / N

Tobacco? Cigarettes ____ Packs/Day Cigars Pipe Chewing Tobacco

Recreational drugs? Y / N

Have you been treated for substance abuse? Y / N

Exercise? Never Rarely Frequently Daily

Do you wear your seatbelt? Y / N

Sex entirely satisfactory? Y / N

Surgeries/ Hospitalizations/ Serious Illnesses-Please list what and Date_____

WOMEN ONLY

Menstrual History

Age at onset_____ Regular Cycle Y / N_____ Days(start to start)

Usual Duration_____ Heavy Moderate Light

Pain or cramps? Y / N

Date of last period_____

PREGNANCIES

How many children_____ How many premature_____

How many C-Sections_____ How many stillbirths_____

How many miscarriages_____

Any complications with pregnancy? Y / N If yes, what?_____

Thank you for taking the time to complete the above

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Payment Policy

It is the policy of EXCEL PHYSICIANS to receive payment in full at the time services are rendered unless other arrangements have been made in advance.

If you wish our office to bill an insurance company, a copy of the insurance card and/or complete billing information is required and must be presented before services are rendered.

Enrollment in an insurance plan is not a guarantee of payment.

Deductibles, co-payment, and patient responsibility amounts are due at the time of services.

EXCEL PHYSICIANS does not assume responsibility for verification of insurance benefits and/or coverage. Please contact your insurance company to verify your benefits and doctor participation in your plan *before* services are rendered.

Any portion of the balance not paid by insurance company due to patient co-pays or deducible amounts, non-covered services, deemed by the insurance company as not medically necessary, doctor non-participation in plan or any other reason for non-payment or reduced payment is the responsibility of the patient or responsible party.

HMO's and some other insurance plans require an authorization for treatment from a specialist and for most procedures. Referrals are submitted to your insurance or IPA after your visit and may take several days. You will be notified by mail or phone call unless your Primary Care Physician deems the referral urgent.

A statement of charges will be sent to the patient each month showing the patient due balance. Delinquent balances may be referred to an outside agency for collection.

I have read the above policy and understand that I am financially responsible for all medical services rendered.

_____ Date _____

(Signature of patient or responsible party)

_____

(Print Name)

ACKNOWLEDGMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____

Patient Name (please print) Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature