excel orthopedics

new patient worksheet

today's date

first name | middle name | last name

home street address | home street address 2

city | state | zip code

home phone number | daytime phone number

emergency contact name | phone number

patient information

gender | social security number

☐ male ☐ female

date of birth | email address

marital status

☐ single ☐ married ☐ divorced ☐ widowed ☐ partnered ☐ other

employer's name | employer's address

race

☐ asian ☐ african american ☐ native american ☐ caucasian ☐ prefer to not answer ☐ other

ethnicity

☐ hispanic ☐ non-hispanic ☐ unknown ☐ prefer to not answer ☐ other

language | military veteran

☐ english ☐ spanish ☐ other ☐ yes ☐ no

are you being seen for a work related injury? | are you being seen for a personal injury claim?

☐ yes ☐ no ☐ yes ☐ no

please provide insurance cards for us to copy

primary insurance | id number | group number

policy holder's name | date of birth | social security number

patient's relationship to insured

☐ self ☐ spouse ☐ child ☐ other

secondary insurance | id number | group number

policy holder's name | date of birth | social security number

patient's relationship to insured

☐ self ☐ spouse ☐ child ☐ other

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assignment of benefits

I hereby assign and convey directly to the Excel Orthopedics, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the above-named health care provider, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize Excel Orthopedics to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named health care provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits.

i have read and fully understand this agreement.

patient signature	date

Excel Orthopedic does not discriminate against Race, Color, Religion, National Origin, Ancestry, Sex or handicap.

payment of services

Payment for services rendered is ultimately the patient responsibility. Your insurance policy is a contract between you and your insurance company. Your responsibility is to give us the correct information about your insurance company. Compliance must be executed with the rules of your insurance provider including but not limited to: valid referral form and pre-certification of testing and/or surgery in order for your claim to be paid. Eligibility for procedures does not always confirm certification, authorization or payment. We will file your insurance claim. If claims are denied because of failure to comply with the insurance company requirements, the denied amount will be your responsibility. For patient balances and self-pay accounts, we accept cash, check, Visa and MasterCard. In the event of non-payment, you will be responsible for any collection and/or legal fees associated with the collection of the balance due.

co-payments and deductibles

As required by your insurance company, you must pay your co-pay at the time of service. Failure to pay is a violation of your contract with your insurance company. The deductible amounts are the patient responsibility. Your insurance is not responsible for reimbursement or payment until the deductible amount is satisfied.

non-covered services

Not all insurance plans cover all services. In the event your insurance plan determines a service to be not covered, you are responsible for the complete charge. We will provide an Advance Beneficiary Notice as needed.

physician non participation in your insurance plan

If you are insured with an insurance plan with which we do not participate you would be responsible for the difference between the billed charges and the “Out of Network” payment. Questions should be directed to your insurance plan.

no insurance coverage

If you do not have insurance coverage, we expect payment in full prior to rendering services. In certain circumstances, payment plans may be made in advance. If you default on your promised payment, we will refer your account to a collection agency.

workers’ compensation claims

We file workers compensation claims, however your employer must approve treatment and the bill for services rendered must be sent to your employer or their Workers’ Compensation carrier. If your employer does not approve treatment and you select us for treatment, you will be responsible for the bill.

lawsuits and third party billing

We will accept third party billing on a case-by-case basis. You are responsible for payment of our regular fees at the time of service unless other arrangements are made in advance with our billing company.

I have read and understand the practice’s financial policy and I agree to be bound by its terms.

patient name and signature

date

acknowledgement of receipt of patient privacy notice

patient name | date

i had access to the excel orthopedics notice of privacy practices

patient/reresentative signature

relationship of representative to patient | date

release of health information to patient representative

on this day, / / , i authorize the folowing people to have access to my health records in order to assist in my medical care:

first person | date of birth | relationship

second person | date of birth | relationship

patient/representative signature

acknowledgement not obtained

on this day, / / , i attempted to get a written acknowledgement of the excel orthopedics' notice of privacy practices but was unable to because:

☐ patient or representative refused to sign ☐ other

staff members signature

phone message authorization

i authorize excel orthopedics to leave appointment reminders on this number:

cell phone number | home phone number | other

patient/representative signature | date

excel orthopedics

review of systems and personal health history

today's date

patient name | date of birth

height (inches) | weight (pounds) | hand dominance ☐ right ☐ left ☐ both

who recommended you see us?

☐ dr. ☐ worker's comp ☐ website ☐ previous patient
☐ friend/family ☐ physical therapist ☐ other

who is your primary care physician? | phone number

allergy/immunologic:

☐ frequent sneezing ☐ hives ☐ itching

cardiovascular

☐ chest pain/arm pain on exertions ☐ leg swelling ☐ shortness of breath when walking

constitutional

☐ fatigue ☐ fever ☐ night sweats ☐ weight gain (lbs) ☐ weight loss (lbs)

ears/nose/throat/mouth

☐ bad breath ☐ bleeding gums ☐ cavities ☐ frequent nosebleeds ☐ nose/sinus problems

Last visit to dentist, Dr. **was on/about**

endocrine

☐ cold intolerance ☐ fatigue ☐ increased thirst

eyes

☐ dry eyes ☐ irritation ☐ vision change ☐ glaucoma

respiratory

☐ cough ☐ wheezing ☐ shortness of breath ☐ coughing up blood ☐ sleep apnea ☐ asthma

gastrointestinal

☐ abdominal pain ☐ black or tarry stools ☐ GERD ☐ vomiting ☐ vomiting blood

genitourinary

☐ difficulty urinating ☐ increased urinary frequency ☐ urinary loss of control

hematologic/lymphatic

☐ easy bruising ☐ excessive bleeding ☐ swollen glands

musculoskeletal

☐ back pain ☐ joint pain ☐ muscle aches ☐ muscle weakness ☐ swelling in the extremities

neurologic

☐ headache ☐ head injury ☐ numbness ☐ seizures ☐ weakness

psychiatric

☐ anxiety ☐ depression ☐ memory loss ☐ sleep disturbances

skin

☐ changes in skin or hair ☐ dry skin ☐ rash ☐ growths/lesions:

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review of systems and personal health history

medical history

hematologic

☐ anemia ☐ hemophilia ☐ bleeding disorder ☐ blood clot ☐ DVT ☐ factor v leiden
☐ pulmonary embolus ☐ seizures ☐ sickle cell anemia ☐ thrombocytopenia ☐ von willebrand disease

immunologic/musculoskeletal

☐ ankylosing spondylitis ☐ erythematosus (SLE) ☐ mysthenia gravis ☐ osteoarthritis ☐ polymyalgia
☐ psoriasis ☐ rheumatica ☐ rheumatoid arthritis ☐ scleroderma ☐ systemic lupus

psychiatric/neurologic

☐ anxiety ☐ depression ☐ bipolar ☐ seizures/epilepsy ☐ stroke/TIA

pulmonary

☐ asthma ☐ COPD ☐ sleep apnea

cardiac/vascular

☐ coronary artery disease ☐ heart attack (MI) ☐ heart problems ☐ hypertension
☐ peripheral vascular disease ☐ vasculitis

gastrointestinal

☐ hepatitis ☐ inflammatory bowel disease ☐ liver disease ☐ ulcers

endocrine

☐ diabetes ☐ gout ☐ high cholesterol ☐ osteoporosis ☐ thyroid problems

cancer

☐ lymphoma ☐ leukemia ☐ lung breast ☐ thyroid ☐ prostate ☐ other

Infectious

☐ HIV or AIDS ☐ tuberculosis ☐ staph infection (ever) ☐ other infection:

Kidney Disease

☐ stones ☐ dialysis

surgical history *please list including dates*

general	date
orthopedic	date
neurologic	date
spinal	date
allergies/reactions	latex allergy ☐ yes ☐ no

medications

excel orthopedics

review of systems and personal health history

social history

are you working? ☐ yes ☐ no | where | occupation

marital status

☐ single ☐ married ☐ separated ☐ divorced ☐ widowed ☐ live alone ☐ lives with others

tobacco use

☐ never ☐ cigarettes **if yes** ☐ < 1pk day ☐ 1-2 pks day ☐ 2-3 pks day ☐ > 3 pks day

☐ e-cigarettes ☐ cigars ☐ pipe ☐ chewing tobacco

number of years used _____ ☐ quit **number of years ago** _____

alcohol use

☐ yes ☐ no **drinks per week:** _____

sporting activities/hobbies

advanced directive

☐ yes ☐ no

blood transfusions acceptable in case of emergency

☐ yes ☐ no

litigation pending

☐ yes ☐ no

family medical history

Examples: *Heart Disease, Lung Problems, Diabetes, Cancer, Connective Tissue Disorder, Bleeding Disorder, Lupus, Rheumatoid Arthritis, Genetic or Hereditary Disorders*

father

mother

brother(s)

sister(s)

son(s) | daughter(s)

excel orthopedics

consent to obtain medication history

Our medical practice has adopted an electronic medical record system in order to improve the quality of our services. This system also allows us to collect and review your "medication history." A medication history is a list of prescription medicines that we or other doctors have recently prescribed for you. This list is collected from a variety of sources, including your pharmacy and your health insurer.

An accurate medication history is very important to helping us treat you properly and in avoiding potentially dangerous drug interactions.

By signing this consent form you give us permission to collect, and give your pharmacy and health plan permission to disclose information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health conditions, such as depression. This information will become part of your medical record.

This medication history is a useful guide, but it may not be completely accurate. Some pharmacies do not make drug history available to us, ad the drug history from your health plan might not include drugs that you purchased without your health insurance. Your medication history might not include over the counter medicines, supplements or herbal remedies. It is still very important for us to take the time to discuss everything you are taking, and for you to point out to us any errors in your medication history.

Additionally, please list your preferred pharmacy in the lines listed below

pharmacy

street address | street address line 2

city | state | zip code

phone number | fax number

I give permission for you to obtain my medication history from my pharmacy, my health plans and my other healthcare providers.

print patient name

signature of patient, parent or guardian | date