EXCEL PHYSICIANS

How did you hear about us? (Circle One)
Insurance Mailer Newspaper Online Ad Friend Former Bristol Park Patient

Name: _____
Address: _____
City:_____ State:_____ Zip Code:_____
Cell Phone:_____ Sex:_____ Birth Date:_____
Work Phone:_____ DL#:_____
Social Security Number:_____ Age:_____
Occupation:_____ Employer:_____ Marital Status: S/M/D/W
Name of friend or relative not living with you:_____ Phone Number:_____

Insurance Company Name:_____
Insurance Member ID: _____
Insurance Policy Holder's Name (if not the patient) _____
Insurance Policy Holder's Date of Birth:_____
Relationship to Patient: _____
Do you have any other medical insurance? YES / NO IF YES, IS IT: PPO / HMO / POS
Insurance Company:_____
Insurance Member ID:_____

If Patient is a Minor or Student:
Given Mother's Name:_____ Home Phone:_____
Home Address:_____
Occupation:_____ Employer:_____
Work Phone:_____
Given Father's Name:_____ Home Phone:_____
Home Address:_____
Occupation:_____ Employer:_____
Work Phone:_____
Please note: If there is any question regarding the bill, the person who is registering today will be responsible for payment. If the 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.

PATIENT OR GUARDIAN SIGNATURE: _____
DATE: _____

ADULT HEALTH INVENTORY

Name:_____ Date of Birth:_____ MALE/FEMALE
Place of Birth: _____
Highest Level of Education:_____
Do you have an advanced directive (Living Will/Power of Attorney): Y/N If yes, please give us a copy.
Please list next of kin:_____

FAMILY HISTORY

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

□ Diabetes _____
□ Kidney Disease _____
□ Heart Disease _____
□ High Cholesterol _____
□ High Blood Pressure _____
□ Convulsion / Epilepsy _____
□ Neurological Disease _____
□ Stroke _____
□ Psychiatric Disease _____
□ Suicide _____
□ Allergies _____
□ Tuberculosis _____
□ Cancer _____
□ Thyroid disease _____
□ Blood Abnormalities _____
□ Other Hereditary Disease _____

PERSONAL HISTORY

Please list any drug allergies/adverse reactions to medications: _____
_____
Please list all medications you are currently taking: _____
_____
Please list all over-the-counter medications you are taking: _____
_____
Please list all vitamins or minerals you are taking: _____
_____

Date of last:

Physical Examination _____
Tetanus Immunization_____
Cholesterol Screen_____
Mammogram_____
Rectal Exam _____
Pap Smear_____
PSA (prostate) _____
Colonoscopy _____

HABITS

Consume alcoholic beverages? Never Rarely Moderate Daily
Have you ever been treated for alcoholism? Y/N
Tobacco? Cigarettes___ packs per day Cigars Pipe Chewing Tobacco Recreational drugs? Y/N
Have you ever been treated for substance abuse? Y/N
Exercise? Never Rarely Frequently Daily
Do you wear your seatbelt? Y/N
Surgeries / Hospitalizations / Serious Illnesses – Please list what and date: _____
_____

WOMEN ONLY

Menstrual History

Age of onset: _____ Regular Cycle? Y/N
Usual duration: _____days 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? _____

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 the insurance company due to patient co-pays or deductible amounts, non-covered services, 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 turned over to an outside agency for collection.

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

_____
Print Name of Patient

_____
Print Name of Parent or Authorized Party (if applicable)

_____ _____
Signature Date

ACKNOWLEDGEMENT OR RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge that I have been provided a copy of the Notice of Privacy Practices. This notice explains how my personal information can be used and disclosed by this medical office. I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____
Print Name of Patient

_____
Print Name of Parent or Authorized Party (if applicable)

_____ _____
Signature Date

If you would like any family or friend to have access to your medical record/information, please fill out the following information:

RELEASE OF MEDICAL RECORDS/INFORMATION:

I, _____, (name)

Give Dr. Peter DeSilva, Dr. Natalia Bilan, or Dr. Alexa DeSilva permission to release any of my medical records or information to discuss with _____(name) who is my _____ (relationship) from _____ to _____(dates applicable)

Patient Signature: _____

Date of birth: _____

Date: _____