

# 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: \_\_\_\_\_

# CHILD HEALTH INVENTORY

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Place of Birth: \_\_\_\_\_ MALE/FEMALE  
Parents Marital Status:  Single  Married  Separated  Divorced

## FAMILY HISTORY

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

<input type="checkbox"/> Diabetes _____	<input type="checkbox"/> Psychiatric Disease _____
<input type="checkbox"/> Kidney Disease _____	<input type="checkbox"/> Suicide _____
<input type="checkbox"/> Heart Disease _____	<input type="checkbox"/> Allergies _____
<input type="checkbox"/> High Cholesterol _____	<input type="checkbox"/> Tuberculosis _____
<input type="checkbox"/> High Blood Pressure _____	<input type="checkbox"/> Cancer _____
<input type="checkbox"/> Convulsion / Epilepsy _____	<input type="checkbox"/> Thyroid Disease _____
<input type="checkbox"/> Neurological Disease _____	<input type="checkbox"/> Blood Abnormalities _____
<input type="checkbox"/> Stroke _____	<input type="checkbox"/> Other Hereditary Disease _____

## PERSONAL HISTORY

Please list any drug allergies/adverse reactions to medications: \_\_\_\_\_

Please list all medications the patient is currently taking: \_\_\_\_\_

Please list all over-the-counter medications the patient is taking: \_\_\_\_\_

Please list all vitamins or minerals the patient is taking: \_\_\_\_\_

Are all of the patients vaccines current? Y / N

If no, please explain: \_\_\_\_\_

Please check below if the patient has had any of the following:

<input type="checkbox"/> Feeding Problems	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Colic	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Mumps	<input type="checkbox"/> Frequent Colds
<input type="checkbox"/> Measles	<input type="checkbox"/> Ear Trouble
<input type="checkbox"/> German Measles	<input type="checkbox"/> Hay Fever
<input type="checkbox"/> Whooping Cough	<input type="checkbox"/> Respiratory Problems
<input type="checkbox"/> Roseola	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Asthma
<input type="checkbox"/> Intestinal Problems	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Bed Wetting
<input type="checkbox"/> Skin Problems	<input type="checkbox"/> Broken Bones
<input type="checkbox"/> Polio	<input type="checkbox"/> Convulsions/Epilepsy
<input type="checkbox"/> Behavior Problems	<input type="checkbox"/> Hyperactivity
<input type="checkbox"/> Bladder/Kidney Infections	<input type="checkbox"/> Headaches
<input type="checkbox"/> Other _____	

Surgeries/Hospitalizations/Serious Illness - Please list what and the date:

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Prenatal and Perinatal History:

Any problems encountered during pregnancy, labor, or delivery?

Y / N If yes, please explain \_\_\_\_\_

Any problems after birth?

Y / N If yes, please explain \_\_\_\_\_

# 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.*

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Print Name of Patient

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Print Name of Parent or Authorized Party (if applicable)

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Signature

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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.*

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Print Name of Patient

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Print Name of Parent or Authorized Party (if applicable)

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Signature

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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: \_\_\_\_\_