EXCEL
ORTHOPAEDIC SPECIALISTS

PATIENT INFORMATION

Last: **First:** **Middle:** **Marital status:**

Street address: **City:** **State:** **Zip:**

Home Phone: **Work Phone:** **Cell Phone:** **E-mail Address:**

Age: **DOB:** **Sex:** **Social Security Number:**

Emergency Name: **Relationship:** **Emergency Phone:**

Employer Name: **Employer Address:**

Primary Care Physician: **Phone:**

Referring Physician: **Phone:**

Race *(optional, pls check one)* [ ]Am.Indian/Alaskan [ ]Asian [ ]African American [ ]Hawaiian/Pacific Islander [ ]White [ ]Hispanic [ ] Other

Ethnicity *(optional, pls check one)* [ ] Hispanic or Latino [ ] Not Hispanic or Latino

Language *(please check one)* [ ] English [ ] Indian [ ] Spanish [ ] Russian [ ] Other

INSURANCE INFORMATION

Person responsible for bill: **Address (if different):**

Primary Insurance Name: **Insurance Phone:**

Primary Insurance Address:

Subscriber's name: **Subscriber's DOB:** **Group Number:** **Policy Number:** **Relationship:**

Secondary Insurance Name: **Insurance Phone:**

Secondary Insurance Address:

Subscriber's name: **Subscriber's DOB:** **Group Number:** **Policy Number:** **Relationship:**

AUTHORIZATION/CONSENT

I hereby authorize Excel Orthopaedic Specialists to furnish information to my insurance carrier in the course of my treatment, and further authorize payment of surgical and/or medical benefits to the physicians. In consideration of medical services rendered or DME product provided, I understand I am responsible for any unpaid balances, including co-payments and/or deductibles and payment is due within ten (10) days of the billing date.

If I am a member of a managed care health plan, I understand I have an obligation to obtain a referral from my primary care physician. If a referral is not obtained, I may be responsible for payment of services.

I give permission to Excel Orthopaedic Specialists to check my prescription eligibility and prescription history.

I acknowledge that I have received a copy of Excel's Notice of Privacy Practices.

Excel Orthopaedic Specialists respects your confidentiality as a very important part of your relationship with us. To protect your confidentiality, we will not routinely leave messages about your healthcare on your voice mail, answering machine or with your spouse, significant other or any other individual unless you specifically give your permission to do so, or as required by law or in the event of a healthcare emergency involving you.

[ ] With my signature below, I give permission to leave messages about my healthcare on my home and/or cell phone, or with my spouse, significant other or the other listed individuals: _____

Patient/Guardian signature *Date*

WORK. PLAY. LIVE. EXCEL.

EXCEL
ORTHOPAEDIC SPECIALISTS

Today's Date: _____

Legal* Name: (First, MI, Last) _____ Preferred Name: _____

Birth* Sex: ☐ Male ☐ Female DOB: _____ Age: _____ Dominant hand: right_____ left_____

Primary Care Physician: _____ Height: _____ Weight: _____

I was referred by: _____ Occupation: _____

Reason for today's visit: ☐Left ☐Right

Date problem began?

Date of injury? ☐ work injury ☐ motor vehicle accident

Things that make the problem worse:

Things that make the problem better:

What has been done for your problem?

☐ X-ray ☐ Ultrasound ☐ MRI ☐ CT ☐ Bone Scan ☐ Physical Therapy ☐ Injection(s)

Medications (over the counter)? Name:

Medications (prescribed)? Name:

Other?

PLEASE LIST ALL MEDICATIONS, DOSE & FREQUENCY (including herbs and vitamins) ☐ NONE

Medication Name	*Dose*	*Frequency*	*Reason for taking this medication*

PLEASE FILL OUT YOUR COMPLETE MEDICAL HISTORY:

High blood pressure?	Y___ N___	Ulcers? Gastrointestinal?	Y___ N___
Diabetes?	Y___ N___	Cancer?	Y___ N___
Heart disease?	Y___ N___	Sleep apnea?	Y___ N___
Asthma? COPD?	Y___ N___	Pregnant?	Y___ N___
Blood clot? Pulmonary embolus?	Y___ N___		
Blood disorders (i.e. hepatitis, HIV)?	Y___ N___	please explain:	
Other (i.e. cholesterol, thyroid)?	Y___ N___	please explain:	

PLEASE LIST ALL ALLERGIC REACTIONS TO MEDICATION (include latex, adhesive tape, etc.) ☐ NONE

PLEASE LIST ALL PAST SURGERIES (i.e. tonsils, appendix, screws, plates, joint replacements, etc.) ☐ NONE

PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM ➡

**While Excel recognizes a number of genders/sexes, many insurance companies and legal entities unfortunately do not. Please be aware the name and sex listed on your insurance must be used for documentation and correspondence.*

Date: _____

Name: _____

DOB: _____

PATIENTS AGE 12 AND OLDER

Tobacco: [ ] never smoked → *Tobacco Control Smartform*
[ ] current smoker How many per day? [ ]5 or less [ ]6-10 [ ]11-20 [ ]21-30 [ ]31 or more *(smoker = pamphlet)*
[ ] former smoker How long has it been? [ ]<1mo [ ]1-3mo [ ]3-6mo [ ]6-12mo [ ]1-5yr [ ]5-10yr [ ]>10yr

Alcohol: [ ] Never [ ] 1 x month [ ] 2-4 x month [ ] 2-3 x week [ ] More than 3 x week → *Audit-C Smartform*

Current Height: _____ Current Weight: _____ → *If red, merge BMI Abnormal + pamphlet*

PATIENTS AGE 65 AND OLDER

Fall Risk: Have you had a fall in the last 12 months?
[ ] No falls → *Fall Risk 1*
[ ] 1 fall without injury → *Fall Risk 2*
[ ] 1 fall with injury* → *Fall Risk 3 + pamphlet*
[ ] 2 or more falls without injury* → *Fall Risk 4 + pamphlet*
[ ] 2 or more falls with injury* → *Fall Risk 5 + pamphlet*

Osteoporosis: Have you ever had a bone density scan? [ ] Yes [ ] No → *If yes, give to Chanthy*
Have you been diagnosed with Osteoporosis? [ ] Yes [ ] No → *If yes, Osteoporosis YES*

Pneumonia: Have you ever been given a Pneumonia Vaccine in your lifetime? [ ] Yes → *Other provider / Administered / Date*
If so, please provide the date: _____ [ ] No → *Source unspec / Not admin / Today's date*

REVIEW OF SYSTEMS

Please check off every item that currently applies to you

[ ] Fever
[ ] Chills
[ ] Headache
[ ] Weight loss
[ ] Hearing loss
[ ] Nose bleeds
[ ] Night cramps
[ ] Vision changes
[ ] Shortness of breath
[ ] Cough
[ ] Chest pain
[ ] Palpitations
[ ] Heartburn
[ ] Asthma
[ ] Abdominal pain
[ ] Rash/hives
[ ] Memory loss
[ ] Seizures
[ ] Recurrent UTI
[ ] Bloody urine (hematuria)
[ ] Depression
[ ] Numbness
[ ] Tingling
[ ] History of DVT/blood clot
[ ] Stroke/TIA
[ ] Sleep apnea

[ ] ***NONE OF THE ABOVE***