

**NEW PATIENT INFORMATION****PATIENT INFORMATION**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI. \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Sex:  Male  Female Marital Status  Single  Married  Divorced  WidowedIs your visit work related?:  Yes  No If yes, Date of Injury: \_\_\_\_\_

Employer Name/Address: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

Were you referred to our office?  Yes  No

How did you hear about your physician or our practice?

 Friend/Relative Referral: \_\_\_\_\_  Doctor: Referring Physician: \_\_\_\_\_ Website  Print Advertisements  Phonebook  Other: \_\_\_\_\_**PARENT/RESPONSIBLE PARTY INFORMATION (adult accompanying minor child)**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI. \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_

**PATIENT INSURANCE INFORMATION \*Please Provide Insurance Card & Photo ID\***

Primary Insurance Company Name: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security # \_\_\_\_\_

Secondary Insurance Company Name: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security # \_\_\_\_\_

I understand that in the event the listed insurance company/s do not make payment for any/all medical services rendered, I am personally responsible for payment of this account in full. I also agree to disclosure of my credit history.

**RELEASE OF MEDICAL INFORMATION**

I hereby authorize Excel Orthopedics, Ltd., to release any and all medical information pertinent to my medical care to my insurance carrier and/or worker's compensation carrier. I authorize release of pertinent information to my employer if my injuries are work related. I understand the information I am authorizing for release is of a confidential nature and is used in referral to other medical providers and to insurance carriers for the purpose of claims processing.

SIGNATURE OF RESPONSIBLE PARTY: \_\_\_\_\_ DATE: \_\_\_\_\_