



First Name _____ MI _____ Last Name _____ Date of Birth ____/____/____

Address _____
Street City State Zip

Home Phone Number _____ Secondary Phone Number _____

Email _____ declined

Employer _____ Occupation _____ Employment Status _____

SS# _____

FINANCIALLY RESPONSIBLE PARTY: ____ Check (✓) if same as patient

First Name _____ MI _____ Last Name _____

Address _____

Date of Birth ____/____/____ Relationship to Patient _____

Home Phone _____ Work Phone _____

INSURANCE INFORMATION:

Primary Insurance _____

ID# _____ GROUP# _____

Policyholder's Name _____ Date of Birth ____/____/____

Policyholder's Address _____

Relationship to patient _____

Employer _____ Occupation _____

Secondary Insurance: _____

ID# _____ GROUP# _____

Policyholder's Name _____ Policyholder's Birth Date _____

Relationship to patient _____

NAME OF:

Primary Care Physician _____ Referring Physician _____ No primary MD

*Were you seen at the Emergency Room or an Urgent Care Center? YES ____ NO ____

If yes, Where? _____

Emergency Contact: Name _____ Phone Number _____

Relationship to Patient _____



Workers' Compensation/ No-Fault Information

Name (please print): _____

Date of Birth ____/____/____

WORKERS' COMPENSATION? Yes No

AUTO ACCIDENT? Yes No

Date of injury: _____

EMPLOYMENT INFORMATION AT TIME OF INJURY (PLEASE PRINT CLEARLY)

Employer Name: _____

Employer Address: _____ Phone: _____

CITY _____ STATE _____ ZIP _____

Contact person: _____ Phone Number: _____

Employment Status: _____

Workers' Compensation/No-Fault Insurance

Carrier Name: _____

Carrier Address: _____

CITY _____ STATE _____ ZIP _____

Phone: _____ Contact Person: _____

Carrier Claim # _____ WCB Case # _____

Social Security # _____
(required for claims)

Signature: _____ Date: ____/____/____

****PLEASE NOTE THAT YOU WILL BE RESPONSIBLE FOR ANY CHARGES IF YOU DO NOT PROVIDE US WITH THE CORRECT BILLING INFORMATION. YOU MAY OBTAIN THIS INFORMATION DIRECTLY FROM YOUR EMPLOYER. THANK YOU**

ALL PATIENTS ARE REQUIRED TO READ AND SIGN BELOW:

PLEASE NOTE: ALL COPAYMENTS ARE PAYABLE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECK, OR CREDIT CARD. INSURANCE AUTHORIZATION AND ASSIGNMENT: I HEREBY AUTHORIZE EXCELSIOR ORTHOPAEDICS TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO EXCELSIOR ORTHOPAEDICS, ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

EXCELSIOR ORTHOPAEDICS “NOTICE OF PRIVACY POLICY” IS AVAILABLE UPON REQUEST.

****I AUTHORIZE MY MEDICAL INFORMATION BE RELEASED TO THE FOLLOWING: _____

SIGNATURE _____ DATE _____

Excelsior Orthopaedics Pain Medicine Policy

Please read this carefully and sign at the bottom. A copy will be provided upon request.

1. I agree to take narcotic medication exactly as instructed. I am NOT ALLOWED TO CHANGE DOSAGE AMOUNTS or to alter the time schedule of taking medication without first talking to my prescribing physician.
2. Narcotics will NOT be phoned in after office hours or on weekends and holidays.
3. You may use only one pharmacy for filling narcotic prescription.
4. The following are conditions for immediate termination of care.
 - a. Obtaining narcotics from any other physician while under our care without our knowledge.
 - b. Altering or forging of a prescription is a felony and will be reported.
5. Patients may be terminated from care with 30 days notice for noncompliance in the taking of their medication.
6. We will not refill prescriptions that have been lost or misplaced. Please be responsible in keeping up with your narcotic prescriptions.
7. Stolen medications will be replaced ONE TIME ONLY if you have a valid police report.
8. In case of intolerance or ineffective narcotic medications, a different prescription could be given, provided the unused portion of the previously prescribed medication is discarded.
9. I am aware that most of the manufacturers of drugs used to treat chronic pain recommend AGAINST THE OPERATION OF HEAVY EQUIPMENT, which includes driving a motor vehicle.
10. I am aware that if I choose to drive a vehicle I could be charged with a DUI.
11. I have been given information about the use of narcotic medications, including but not limited to, possible risk and adverse side effects such as the development of tolerance, dependence, addiction, withdrawal, constipation, nausea, itching, harmful effects to an unborn child, urinary retention, impairment of reasoning and judgment and depression of breathing.
12. I will not combine any narcotic medications with the consumption of alcohol.
13. I will not give, trade, or sell pain medication.
14. I will allow up to two business days for a prescription refill to be completed. I also understand that request received after 4 pm are handled on the next business day. Prescriptions are filled 8:30am-4:00 pm (Monday-Friday only).
15. I understand that narcotics will be only authorized for 90 days following any surgical procedure.
16. If you have not been evaluated by your orthopaedic physician within the past 90 days, you may be instructed to make a follow-up appointment before any further narcotic medication is given. You may be referred to your PCP, and or pain management.

I have read and understand the above policy and agree to abide by its terms:

Patient Name (please print) (Required)

Patient signature (Required)

Date