Davis Family Medicine
222 N. 2nd Street, Suite 204
Boise, ID 83702
208.429.9100 fax 208.429.9118
www.davisfamilymedicine.net
health care for all ages!

Thank you for choosing Davis Family Medicine. From pediatrics to geriatrics . . . We value you and we **desire to help you live the healthiest life possible!**

Founded by Dr. Ashley Davis in March 2005, Davis Family Medicine offers comprehensive medical services for all ages. As a primary care physician, Dr. Davis enjoys taking time to resolve patients' concerns. She values partnering with patients in decisions about their care.

Same day appointments when you're sick.

Family Practice

- Well Baby/Child Exam
- Immunizations
- Adult & School Physicals
- Well Woman Exams
- Management of Acute & Chronic Illnesses
- Vasectomy & Birth Control
- ADD/ADHD
- Menopausal Care

Dermatology

- Skin Cancer
- Mole Removal
- Acne
- Maintenance of Healthy Skin

Office Hours: 8am – 4pm

Monday through Friday

Allergy Treatment

Celiac Disease (Gluten

Allergy/Intolerance)

Other

- Sports Medicine &Joint Injections
- Bariatric Medicine
- Foot care

On-Site Blood Draws

New Patient Information

Patient's Last Name _____First Name_____ MI ____
Preferred Name _____ Date of Birth _____ Age _____ Sex: F M Preferred Gender: F M
Address _____City _____ State _____ Zip _____
Name of previous Physician / Pediatrician_____
How did you hear about Dr. Davis or Davis Family Medicine? _____
Marital/Partner Status: _____ Student Status: Part-Time Full-Time
Home Phone _____ Day Phone _____Cell Phone _____
(please circle best number to call for appointment reminder)

Employer:_____ Employer Address: _____
Current Occupation? _____ ☐ Retired?
Name of Spouse / Partner: _____ Age _____ Occupation_____
Emergency Contact/Relationship: _____ Phone #: _____

Primary Medical Insurance (only fill out items in bold if you have given us this insurance ID card)
Policy Holder's Name _____ **SSN** _____ **Policy Holder DOB** _____
Plan Name _____ Policy Holder # _____
Patient's Policy # _____Group Name (if applicable) _____
Group Number (if applicable) _____
Ins. Co. Address _____ Ins. Co. Phone Number _____
Effective Date _____ Co-pay Amount _____ **Deductible** _____

Secondary Medical Insurance (only fill out items in bold if you have given us this insurance ID card)
Policy Holder's Name _____ **SSN** _____ **Policy Holder DOB** _____
Plan Name _____ Policy Holder # _____
Patient's Policy # _____Group Name (if applicable) _____
Group Number (if applicable) _____
Ins. Co. Address _____ Ins. Co. Phone Number _____
Effective Date _____ Co-pay Amount _____ **Deductible** _____

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information. I authorize the release of any medical information necessary to process an insurance claim and request that payment of benefits be made to the physician unless my account has been paid in full. **I have received Davis Family Medicine's notice of privacy practice.**

Responsible Party Signature: _____ **Date:** _____

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Patient Name: _____ **DOB:**_____ **Date:**_____

This intake form is just a way of getting to know your health and asking "What do we need to work on together?"

Male ☐ **Female** ☐ **Religion/Spirituality** _____(optional)

ALLERGIES to medication (please describe): _____

MEDICATIONS YOU ARE CURRENTLY TAKING (Rx, OTC, or herbal) ☐ **None**

1.	3.	5.	7.
2.	4.	6.	8.

Pharmacy Name (please include street)_____

Current Tobacco Use? Y / N Former use? Y / N Type:_____ **Amount per day:**_____
How many drinks containing alcohol do you have, on average, per week? _____
Any prior history of IV or street drug abuse? Y / N Exposed to second hand smoke? Y / N
Caffeine consumption? Y / N Type: _____ **Drinks per day?** _____
Are you currently adhering to any special diet (please describe)? _____

Medical/Surgical History: Have you ever been diagnosed any of with the following?

Cardiovascular:		**Details**
Coronary Artery Disease	☐ **Yes**	_____
Elevated Cholesterol (hyperlipidemia)	☐ **Yes**	_____
High Blood Pressure (hypertension)	☐ **Yes**	_____
Gastrointestinal:		
Hepatitis	☐ **Yes**	_____
Bowel problems	☐ **Yes**	_____
Gastro esophageal Reflux	☐ **Yes**	_____
Genitourinary:		
Prostate enlargement (Prostatitis)	☐ **Yes**	_____
Kidney Stones (Nephrolithiasis)	☐ **Yes**	_____
Acute Renal Failure	☐ **Yes**	_____
Eye / Ear / Nose / Throat:		
Cataracts	☐ **Yes**	_____
Glaucoma	☐ **Yes**	_____
Chronic ear infections (otitis media)	☐ **Yes**	_____
Hearing loss	☐ **Yes**	_____
Sinus problems (chronic sinusitis)	☐ **Yes**	_____
Nasal polyps	☐ **Yes**	_____
Nasal allergies	☐ **Yes**	_____
Recurrent tonsillitis	☐ **Yes**	_____
Tinnitus	☐ **Yes**	_____
Vertigo	☐ **Yes**	_____
Hematologic :		
Anemia	☐ **Yes**	_____
Immunologic:		
Allergies Type: _____	☐ **Yes**	_____
Food Allergies Type: _____	☐ **Yes**	_____
HIV / AIDS	☐ **Yes**	_____

Infectious Disease:		**Details**
Mononucleosis	☐ **Yes**	_____
STD Type: _____	☐ **Yes**	_____
Metabolic/endocrine:		
Diabetes Type: _____	☐ **Yes**	_____
Thyroid deficiency (hypothyroidism)	☐ **Yes**	_____
Thyroid excess (hyperthyroidism)	☐ **Yes**	_____
Neoplastic:		
Cancer Type: _____	☐ **Yes**	_____
Neurologic:		
Migraine	☐ **Yes**	_____
Obstetric:		
Pregnancy Date(s): _____	☐ **Yes**	_____
Psychiatric:		
Adjustment Disorder - Anxiety	☐ **Yes**	_____
Major Depression	☐ **Yes**	_____
Pulmonary:		
Asthma	☐ **Yes**	_____
COPD/Emphysema	☐ **Yes**	_____
Sleep Apnea	☐ **Yes**	_____
Pneumonia	☐ **Yes**	_____
Miscellaneous:		
Autoimmune disease	☐ **Yes**	_____
Miscellaneous PEDIATRIC:		
Complications during Pregnancy	☐ **Yes**	_____
Complications during Delivery	☐ **Yes**	_____
NICU stay >48hrs:_____	☐ **Yes**	_____
Preterm birth	☐ **Yes**	_____

OTHER:_____

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Any Prior Surgery?

Type and year:_____ **Type and year:**_____
Type and year:_____ **Type and year:**_____
Type and year:_____ **Type and year:**_____

Family Health History **Adopted?** _____

Family Members: **E= Excellent health G=Good F= Fair P=Poor**

Name	Living: Age	Health	Deceased: Age	Cause
Father:				
Mother:				
Brother/ Sis:				
Spouse:				
Children:				

Medical conditions that run in your family: **List details or state who had this problem?**

ADD/ADHD	☐ **Yes** _____	Hearing deficiency	☐ **Yes**_____
Alcoholism	☐ **Yes** _____	Hyperlipidemia	☐ **Yes**_____
Allergies	☐ **Yes** _____	Hypertension	☐ **Yes**_____
Alzheimer's Disease	☐ **Yes** _____	Irritable Bowel	☐ **Yes**_____
Asthma	☐ **Yes** _____	Learning disability	☐ **Yes**_____
Blood disease	☐ **Yes** _____	Mental illness	☐ **Yes**_____
Heart Disease	☐ **Yes** _____	Migraines	☐ **Yes**_____
CAD-Premature	☐ **Yes** _____	Obesity	☐ **Yes**_____
Osteoarthritis	☐ **Yes**_____	Osteoporosis	☐ **Yes**_____
CVA (Stroke)	☐ **Yes** _____	Eczema	☐ **Yes** _____
Depression	☐ **Yes** _____	Blood Clots	☐ **Yes**_____
Developmental delay	☐ **Yes** _____	Renal disease	☐ **Yes**_____
Diabetes (Type I or II?)	☐ **Yes** _____	Seizure disorder	☐ **Yes**_____
Cancer	☐ **Yes** Type(s) and Who had it? _____		

_____

_____

Other medical conditions in your family?_____

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HIPAA COMPLIANCE

I have been provided information on how Davis Family Medicine may use my health information to provide my health care service. This notice also includes information on how I may access my health information.

Should I have any questions regarding the Notice of Privacy Practices, a copy will be made available to me upon my request.

_____

Print patient name

_____ _____

Patient or responsible party signature date

_____

Print responsible party name and relationship to patient

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Authorization to Disclose Health Information

name: _____ **date of birth** _____ **phone #** _____

please obtain information from:

_____
name of provider/clinic

_____
street address

_____
city, state, zip

phone:_____ **fax:**_____

please send information to:

Davis Family Medicine
222 N. 2nd Street, Suite 204
Boise ID 83702

phone: 208.429.9100

fax: 208.429.9118

I authorize the following information to be disclosed. (Please initial all that apply.) Via fax or mail. (circle one)

___ entire record
___ immunization record
___ lab results
___ TB test
___ HIV record
___ STD record
___ psychological/mental health
___ alcohol/substance abuse
____ billing records
____other _____

Reason for disclosure of health information (please initial):

___ at my request
___ continuing care
___ insurance
___ job
___ school
___ other _____
___ legal

Expiration of this authorization: (Please initial one.)

___ 90 days after signature date
___ on the following date _____
___ when this event happens _____

Additional patient information:

I understand that I have the right to withdraw this authorization.
I understand that I do not have to sign this authorization to get treatment.
I understand that once my health care information is disclosed as I have authorized, could be redisclosed by the recipient and is no longer protected by Davis Family Medicine.
I understand that signing this authorization does not cancel any rights I have under other State or Federal laws.

_____ _____ _____
patient/parent/legal representative **relationship** **date**

Clinic Policies

Welcome to Davis Family Medicine! We are so glad that you have chosen us to care for your health. From pediatrics to geriatrics, we value you and help you to live the healthiest life possible. Here's some important information about our office . . .

First appointment: Please bring your insurance card, photo ID, new patient forms, names and phone numbers of any former physicians (for prior records) and your co-payment.

Subsequent appointments: Please bring your insurance card and co-payment. Per contractual agreement with our insurance carriers, we must collect your co-payment at the time of service. For your convenience, we accept VISA and Master Card, checks and cash.

Scheduling appointments: A great part of family practice is that we provide healthcare for the entire body. This makes family practice a bit tricky, too. Sometimes patients have more than one problem going on. Each problem or concern needs to be given full attention, so when you schedule an appointment, the receptionist will ask you for one problem to discuss at your appointment. You might need to return for another visit if you have an unrelated problem that needs to be addressed.

Appointments no-show or cancellations: If you are unable to keep your appointment, we ask that you give us a 24 hour notice so that we can try to re-fill your slot. If you give less than a 24 hour notice, we will assess you a $50 fee in order to recover our staffing and office costs for the missed appointment.

Wellness exams: The Wellness Exam gives the provider a chance to update you on cancer prevention, heart disease prevention, osteoporosis prevention and vaccinations. The Wellness Exam is not for illness or other problems. If you bring up a health problem during your wellness exam, the provider will likely decide to treat the health problem and then reschedule your wellness exam. If both are done on the same day, you may be charged for both a wellness exam and a regular office visit.

Lab and x-rays: It is our firm professional belief that to provide you with the best possible health care, we must meet with you face-to-face to review lab results, both normal and abnormal. That means that an appointment must be scheduled to review lab results. We cannot review a lab report over the phone.

Phone calls: Your phone call is very important to us. A nurse, scheduler or administrative staffer will be happy to answer your questions over the phone. If the nurse cannot answer your question to your satisfaction, then you must schedule an appointment with a provider.

Prescription refills: For chronic illness, we provide enough refills to get you through to your next maintenance visit. If you have run out of your refills, it means it is time to schedule an appointment!

Returned checks: If a check you have written to us is returned by our bank for insufficient funds, we will assess you a $30 fee for the administrative cost as well as bank fees and, in the future, we will only be able to take cash or credit card from you.

Account Balances: Payment is due at the time of service. As a courtesy we will bill your health insurance carrier for you and your portion is due as soon as we receive the EOB. Patients with balances over $200 may not make appointments with our clinic until their balance is $200 or under. If it becomes necessary for us to use an outside agency to collect payment, you will be additionally responsible for charges we incur as a result.

Davis Family Medicine reserves the right to update and revise these polices and guidelines at any time. This brochure does not include every policy at Davis Family Medicine. It is simply a guide to understand how we operate.

I have read the above policies of Davis Family Medicine.

_____	_____	_____
Print patient name	**Patient signature**	**Date**

Financial Agreement with Davis Family Medicine

Insurance Plans: You will be responsible for any balance your insurance plan indicates as due on their explanation of benefits form. We will adjust the charges to coincide with your plan's UCR (Usual, Customary and Reasonable) charges. All patients will be responsible for their co-insurance and deductible. If we do not "participate" with your plan, we will send a courtesy bill to that carrier on your behalf. However, should they not pay your claim within 45 days, you will be responsible for the full amount due. Should you receive payment from your insurance carrier, please forward it to the physician's office.

Self-pay Patients: Payment is expected at time of service.

Divorced/Separated parents of minor patients: The parent who consents to the treatment of a minor child is responsible for payment of services rendered. Davis Family Medicine will not be involved with separation or divorce disputes.

Payment is due at the time of service. As a courtesy we will bill your health insurance carrier for you and your portion is due as soon as we receive the EOB. Patients with balances over $200 may not make appointments with our clinic until their balance is $200 or under. If it becomes necessary for us to use an outside agency to collect payment, you will be additionally responsible for charges we incur as a result.

I have read and understand the financial policy and the clinic policies of Davis Family Medicine.

_____ _____

Print patient name **date of birth**

_____ _____

Patient signature or responsible party signature **date**

_____

Print responsible party name and relationship to patient

Private Insurance Authorization for Assignment of Benefits/Information Release

I, the undersigned, authorize payment of medical benefits to Davis Family Medicine for any services furnished. I understand that I am financially responsible for any amount not covered by my contract. I also authorize any holder of medical information about me to release to my insurance company (or their agent) information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

_____ _____

Print patient name **date of birth**

_____ _____

Patient or responsible party signature **date**

_____

Print responsible party name and relationship to patient

Medicare Lifetime Signature on File

I, the undersigned, request payment of authorized Medicare benefits be made on my behalf to Davis Family Medicine for any services furnished to me. I authorize any holder of medical information about me to release to THE CMA (and its agents) any information to determine these benefits payable for related services. This information will be used for the purpose of evaluating and administering claims of benefits.

_____ _____

Print patient name **date of birth**

_____ _____

Patient or responsible party signature **date**

_____

Print responsible party name and relationship to patient