



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: _____
Address _____ City _____ State _____ Zip _____
E-mail address: (for e-statements) _____
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: _____



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:

- 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:

- 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: _____



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

Medical conditions that run in your family:

- Yes ADD/ADHD _____
- Yes Alcoholism _____
- Yes Allergies _____
- Yes Alzheimer's Disease _____
- Yes Asthma _____
- Yes Blood disease _____
- Yes Heart Disease _____
- Yes CAD-Premature _____
- Yes Osteoarthritis _____
- Yes CVA (Stroke) _____
- Yes Depression _____
- Yes Developmental delay _____
- Yes Diabetes (Type I or II?) _____
- Yes Cancer _____ Type(s) and Who had it? _____

List details or state who had this problem?

- Yes Hearing deficiency _____
- Yes Hyperlipidemia _____
- Yes Hypertension _____
- Yes Irritable Bowel _____
- Yes Learning disability _____
- Yes Mental illness _____
- Yes Migraines _____
- Yes Obesity _____
- Yes Osteoporosis _____
- Yes Eczema _____
- Yes Blood Clots _____
- Yes Renal disease _____
- Yes Seizure disorder _____

Other medical conditions in your family? _____



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



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 any issue requires more than 3 phone calls with a nurse, there will be a \$25 charge per call after the 3rd call. 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 policies 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