



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  
429-9100*

## Allergy Treatment

Celiac Disease (Gluten Allergy/Intolerance)

## Other

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

On-Site Blood Draws



# Pediatric 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? \_\_\_\_\_  
 Mother's Full Name \_\_\_\_\_ Mother's address \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Day Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 (please circle best number to call for appointment reminder)  
 Mother's Employer: \_\_\_\_\_ Employer Address: \_\_\_\_\_  
 Current Occupation? \_\_\_\_\_  Retired?  
 Name of Spouse / Partner: \_\_\_\_\_ Age \_\_\_\_\_ Occupation \_\_\_\_\_  
 Father's Full Name \_\_\_\_\_ Father's address \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Day Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 (please circle best number to call for appointment reminder)  
 Father's Employer: \_\_\_\_\_ Employer Address: \_\_\_\_\_  
 Current Occupation? \_\_\_\_\_  Retired?  
 Name of Spouse / Partner: \_\_\_\_\_ Age \_\_\_\_\_ Occupation \_\_\_\_\_  
 Other 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 child's health and asking "What do we need to work on together?"

Male  Female  Religion/Spirituality \_\_\_\_\_ (optional)

ALLERGIES to medication (please describe): \_\_\_\_\_

MEDICATIONS CHILD IS CURRENTLY TAKING (Rx, OTC, or herbal)  None

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

Pharmacy Name (please include street) \_\_\_\_\_

Is child currently adhering to any special diet (please describe)? \_\_\_\_\_

Social History: Parents: single / divorced / married Smoker's in home? yes no

Guns in home: yes no Loaded? yes no Locked? yes no

Free time activities: \_\_\_\_\_

Exercise? yes no Sports activities? \_\_\_\_\_

Hours of TV per day? \_\_\_\_ Seat belts always used when in a car? yes no bike helmet always used? yes no

Medical/Surgical History: Have the child 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 Surgery?**

Type and year: \_\_\_\_\_ Type and year: \_\_\_\_\_

**Family Health History**

Adopted? \_\_\_\_\_

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

Name	Living:		Deceased:		Lives in home with child?	
	Age	Health	Age	Cause	Yes	No
Father:					Yes	No
Mother:					Yes	No
Brother/ Sisters:					Yes	No
					Yes	No
					Yes	No
					Yes	No
					Yes	No
					Yes	No
Others who live in home with child:						

**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(s) Type 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.

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Print patient name

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Patient or responsible party signature

---

date

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Print responsible party name and relationship to patient



**Authorization to Disclose Health Information**

**name:** \_\_\_\_\_ **date of birth** \_\_\_\_\_ **phone #** \_\_\_\_\_

**please obtain information from:**

**please send information to:**

1. \_\_\_\_\_ **Fax#** \_\_\_\_\_  
**name of provider/clinic**

**Davis Family Medicine**  
**222 N. 2<sup>nd</sup> Street, Suite 204**  
**Boise ID 83702**

2. \_\_\_\_\_ **Fax#** \_\_\_\_\_  
**name of provider/clinic**

**phone: 208.429.9100**

3. \_\_\_\_\_ **Fax#** \_\_\_\_\_  
**name of provider/clinic**

**fax: 208.429.9118**

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

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> entire record       | <input type="checkbox"/> HIV record                  | <input type="checkbox"/> billing records |
| <input type="checkbox"/> immunization record | <input type="checkbox"/> STD record                  | <input type="checkbox"/> other _____     |
| <input type="checkbox"/> lab results         | <input type="checkbox"/> psychological/mental health |  |
| <input type="checkbox"/> TB test             | <input type="checkbox"/> alcohol/substance abuse     |  |

**Reason for disclosure of health information (please initial):**

- |  |                                 |                                      |
|--|---------------------------------|--------------------------------------|
| <input type="checkbox"/> at my request   | <input type="checkbox"/> job    | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> continuing care | <input type="checkbox"/> school | <input type="checkbox"/> legal       |
| <input type="checkbox"/> insurance       |                                 |                                      |

**Expiration of this authorization: (Please initial one.)**

- 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! 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 3<sup>rd</sup> 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 and understand the above policies of Davis Family Medicine.**

\_\_\_\_\_  
**Print Responsible Party Name**

\_\_\_\_\_  
**Responsible Party 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