



PATIENT INFORMATION

First Name _____

Social Security # _____

Middle Name _____

Gender M F

Last Name _____

Date of birth _____

Suffix _____ Marital Status S M D W

Cell Phone _____

Address _____

Home Phone _____

City, state, zip _____

Employer/School _____

Work phone _____

Emergency contact name _____

Relationship to patient _____

Emergency Contact number _____

Is your current problem a workman's compensation claim? Yes No

** A workman's compensation claim is when an injury occurs in the performance of your work duties and your employer has been notified of the injury. Dr. Davis is not accepting new work comp patients.*

INSURANCE INFORMATION

***Dr. Davis only participates with and files Blue Cross insurances.**

Primary Insurance _____

ID/Member Number _____

Policy holder first name _____

Group number _____

Policy holder last name _____

*Policy holder date of birth _____

Policy holder relationship to patient _____

*Policy holder social security _____

Employer _____

Work phone _____

Secondary Insurance _____

ID/Member Number _____

Policy holder first name _____

Group number _____

Policy holder last name _____

Policy holder date of birth _____

Policy holder relationship to patient _____

Policy holder social security _____

Employer _____

Work phone _____



HIPAA Notice of Privacy Practices

Patient: _____

Email Usage:

I give my permission for Davis Orthopedics to communicate with me via email regarding my medical, account, and appointment information. Your email address will not be shared with anyone else.

_____ ***PRINT CLEARLY.**

Email address.

Release of Information

- I want Davis Orthopedics to communicate **only with me** regarding my medical, account, and appointment information.
- I give my permission to Davis Orthopedics to release my medical, account, and appointment information to **my family members or individuals** involved in my care.
- I give my permission to Davis Orthopedics to release my medical, account, and appointment information to the following **specific people that are not family members**.

Restrictions:

- Davis Orthopedics is **restricted** from releasing my medical, account, and appointment information to the following specific person(s).

I have been provided a copy of Davis Orthopedics' HIPAA Notice of Privacy Practices and have been notified of the above information.

Signature of Patient/Account Guarantor

Date



Patient's Full Name _____ Age: _____ Date: _____

CURRENT COMPLAINT: (Dr. Davis will only evaluate/treat up to 2 body parts per visit.)

What body part is affected?

- Neck, Shoulder (Right/Left), Hip (Right/Left), Other:
Upper back, Elbow (Right/Left), Knee (Right/Left)
Lower back, Wrist (Right/Left), Ankle (Right/Left)
Hand (Right/Left), Foot (Right/Left)

How long have your symptoms been present? ___ Days ___ Weeks ___ Months ___ Years

If you had a specific injury, please provide date (month/day/year) ___/___/___

Describe injury: _____

Is your current problem a workman's compensation claim? Yes No

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CURRENT MEDICATIONS

Table with 3 columns: MEDICATION, DOSE, REASON FOR MEDICATION

ALLERGIES - MEDICATION or LATEX

Table with 2 columns: MEDICATION or LATEX, REACTION

*Preferred Pharmacy: _____

Phone: _____

Address/location: _____

CURRENT MEDICAL PROBLEMS: (those requiring current treatment)

- ___ congestive heart failure ___ acid reflux ___ ADD/ADHD ___ arthritis
___ mitral valve prolapse ___ Crohn's ___ Alzheimer's ___ Rheumatoid arthritis
___ high blood pressure ___ GERD ___ anxiety ___ herniated disc
___ DVT ___ IBS ___ dementia ___ osteoporosis
___ angina ___ peptic ulcer ___ depression ___ osteomyelitis
___ stroke ___ ulcerative colitis ___ bipolar ___ neuropathy
___ arrhythmia ___ kidney disease ___ Diabetes ___ restless leg
___ anemia ___ HIV ___ diverticulitis ___ gout
___ bleeding ___ Lupus ___ BPH ___ blindness
___ Thrombocytopenia ___ Asthma ___ Cancer ___ deafness
___ COPD ___ Hepatitis ___ hyperthyroid
___ vertigo ___ Sickle cell ___ hypothyroid

Other: _____

PREVIOUS MEDICAL PROBLEMS: [] None

HEART: ___ Heart attack ___ Heart defect ___ Heart valve ___ Coronary artery disease ___ Stent ___ Angioplasty

CANCER: _____

___ Peptic ulcer ___ Peripheral vascular disease ___ diabetes ___ kidney disease
___ Blood clot ___ DVT ___ Pulmonary embolism ___ Bleeding disorder _____

Immune system disorder _____

PREVIOUS SURGERIES:



Matthew S Davis, M.D.
Orthopedic Surgery & Sports Medicine

Authorization for Medical Treatment: The undersigned has been informed of the treatment procedures considered necessary for the patient and that the treatment will be directed by a physician, Matthew S. Davis, M.D., and performed by employees of Davis Orthopedics. The undersigned understands that no guarantee for assurance has been made as to the results that may be obtained from treatment. Authorization is hereby granted for treatment.

Information Privacy: Davis Orthopedics will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice at our facilities, on our website, and have copies available for distribution. The undersigned acknowledges receipt of this information.

Release of Information: Davis Orthopedics is hereby authorized to disclose all or part of my information regarding medical condition, treatment and prognosis to insurance carriers, other treating physicians, trainers, and rehabilitation professionals.

Assignment of Insurance Benefits: Dr. Davis is a participating provider with Blue Cross insurance. *Payment of co-pays, coinsurance, and deductibles is required. If you have not met your deductible, a \$100 upfront payment is required.* In the event the undersigned is entitled to benefits of any kind whatsoever arising out of any policy of insurance insuring the patient or any other party liable to the patient, said benefits are hereby assigned to Davis Orthopedics for application on the patient's bill. The undersigned and/or patient agree to be responsible for obtaining referrals, charges not covered by the assignment, including deductibles and co-payments prescribed by law.

Financial Agreement: The undersigned agrees that in consideration for the services to be rendered to the patient, he/she individually agrees to be totally responsible for all charges for services, including any non-covered charges. Should the account be referred to an attorney or collection agency for collection, the undersigned agrees to pay a **\$50** collection fee plus all costs of collection and attorney fees. *As a courtesy to our patients, we will file participating insurance claims for the services rendered by this office. After the insurance has been processed, all balances are due within 30 days. Any balance not paid within the allotted time will accrue late penalties, including a \$5.00 monthly billing fee.*

Miscellaneous Provisions: I understand that under no circumstances will Davis Orthopedics be liable for the property of patients.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ AND UNDERSTANDS THE FOREGOING, IS THE PATIENT OR ONE AUTHORIZED BY THE PATIENT TO EXECUTE THE ABOVE, AND ACCEPTS THE TERMS THEREOF.

Patient's name: _____ Social security number: _____

Patient's signature: _____ Date of signing: _____

****If patient is a minor, age 18 or younger, the responsible person (parent or guardian) needs to complete the following. The adult that accompanies the minor patient is the guarantor (responsible party) for the account, not necessarily the insurance policy holder.**

Patient's name: _____ Date of birth: _____

*Person Responsible for account: _____ Relationship to patient: _____

*Responsible party's Social security number: _____ *Date of birth: _____

Responsible party's signature: _____ Date of signing: _____

Responsible party's address: _____