**Patient Registration**

## *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 __________________________________________

*Matthew S Davis, M.D.*

**Orthopedic Surgery & Sports Medicine**

**HIPAA Notice of Privacy Practices** **Effective 03/16/2023**

**Patient: ___________________________________________________________________**

**Text and Email Usage**:

______________________________________________________________________*PRINT CLEARLY.

**Cell phone number**

______________________________________________________________________*PRINT CLEARLY.

**Email address**.

I give my permission for Davis Orthopedics to communicate with me via text and email regarding my medical,

account, and appointment information. Your phone number and email address will not be shared with anyone else.

**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**

Davis Orthopedics

**New Patient - Injury/Accident/Med History Details**

**Patient's name:** ___________________________________________

**How did you hear about Dr. Davis?** [] Google [] Family/Friends [] Dr ______________________________

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

What body part is affected?

Neck | Upper back | Lower back

Shoulder (Right/Left) | Elbow (Right/Left) | Wrist (Right/Left) | Hand (Right/Left)

Hip (Right/Left) | Knee (Right/Left) | Ankle (Right/Left) | Foot (Right/Left)

Other: ____________________________________________________________________________________________

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: ______________________________________________________________________________________

**CURRENT MEDICATIONS**

| MEDICATON | DOSE | REASON FOR MEDICATION |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**ALLERGIES – MEDICATION or LATEX**

| MEDICATION or LATEX | REACTION |
|---|---|
| | |
| | |
| | |

***Preferred Pharmacy**: ________________________________ **Phone:** ______________________________________

Location/Address: _________________________________

**CURRENT MEDICAL PROBLEMS**: (those requiring current treatment)

___ congestive heart failure
___ mitral valve prolapse
___ high blood pressure
___ DVT
___ angina
___ stroke
___ arrhythmia
___ anemia
___ bleeding
___ Thrombocytopenia
___ COPD
___ vertigo

___acid reflux
___ Crohn's
___ GERD
___ IBS
___ peptic ulcer
___ ulcerative colitis
___ kidney disease
___ HIV
___ Lupus
___ Asthma
___ Hepatitis
___ Sickle cell

___ ADD/ADHD
___ Alzheimer's
___ anxiety
___ dementia
___ depression
___ bipolar
___ Diabetes
___ diverticulitis
___ BPH
___ Cancer
___ hyperthyroid
___ hypothyroid

___ arthritis
___ Rheumatoid arthritis
___ herniated disc
___ osteoporosis
___ osteomyelitis
___ neuropathy
___restless leg
___ gout
___ blindness
___ deafness

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: _____________________________________________________________________________

Phone: (205) 533-6644 Fax: (888)258-4852
St. Vincent's 119 Health & Wellness Center
7191 Cahaba Valley Rd., Suite 205
Birmingham, AL 35242