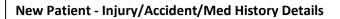
P	ati	iei	٦t	Re	gis	tra	ti	on	
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PATIENT INFORMATION

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				
* 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			
	, ,			

HIP/	AA Notice of Privacy Practices	Effective 03/16/2023
Patio	ent:	
<u>Text</u>	t and Email Usage:	
		*PRINT CLEARLY.
Cell	phone number	
 Ema	iil address.	*PRINT CLEARLY.
I give	e my permission for Davis Orthopedics to commur	nicate with me via text and email regarding my medica
acco	ount, and appointment information. Your phone n anyone else.	umber and email address will not be shared with
<u>Rele</u>	ease of Information	
[]	I want Davis Orthopedics to communicate onl appointment information.	y with me regarding my medical, account, and
[]	I give my permission to Davis Orthopedics to rinformation to my family members or individ	
[]	I give my permission to Davis Orthopedics to reinformation to the following specific people th	
Rest	<u>trictions</u> :	
[]	Davis Orthopedics is restricted from releasing the following specific person(s).	my medical, account, and appointment information to
	ve been provided a copy of Davis Orthopedics' HIP ne above information.	AA Notice of Privacy Practices and have been notified
Sign	nature of Patient/Account Guarantor	 Date





	Patient	's name:			
How did you he	ar about Dr. Da	vis? [] Google	[] Family/Friends	[] Dr	
	-	is will only evaluate/t	reat up to 2 body parts per	r visit.)	
What body part is					
Neck	Upper b		Lower back		1/5: 1. // 6)
Shoulder (Right/Le		-	Wrist (Right/Left)		nd (Right/Left)
Hip (Right/Left)		-	Ankle (Right/Left)	FOC	ot (Right/Left)
Other.					
If you had a specif	fic injury, please p		DaysWeeks ay/year)//		Years
			CURRENT MEDIC	CATIONS	
MEDICATON	DOSE	REASON FOR		MEDICATION or	LATEX
		MEDICATION			
			MEDICATION o	or I ATFX	REACTION
	•	•	<u></u>		
*Preferred Phar	macy:		Phone:		
		(those requiring curr		ID.	- male otati-
	eart failure		ADD/ADF Alzheime		arthritis
mitral valve p high blood pro		Crohn's GERD		er S	Rheumatoid arthritis herniated disc
DVT	essure	IBS	anxiety dementia	.	osteoporosis
angina		peptic ulcer	depression		osteomyelitis
stroke		ulcerative colitis	bipolar) ii	neuropathy
arrhythmia		kidney disease	Diabetes		restless leg
		HIV	diverticul		gout
bleeding		Lupus	BPH		blindness
		Asthma	Cancer		deafness
COPD	•	Hepatitis	hyperthy	roid	
vertigo		Sickle cell	hypothyr		
Other:			,,		
PREVIOUS MEDI HEART:Heart		••	one lveCoronary artery dis	sease	StentAngioplasty
CANCER:			·		· ·
Peptic ulcer	Peripheral vas			kidney disease	
Blood clot	DVT		Pulmonary embolism	Bleeding disorder	·
Immune system d	isorder			•	
PREVIOUS SURG	SERIES:				

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:
	esponsible person (parent or guardian) needs to complete the following. patient is the guarantor (responsible party) for the account, not .
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:	