



DUBLIN MEDICAL CENTER
FAMILY MEDICINE

ROBERT A. DAVIS, MD *Family Practice*

Robert A. Davis, MD
Joy M. Davis, MSN, CRNP
Natasha L. Worthington, PA-C

Patient Information -

Date: _____

Patient Name: _____ Date of Birth: _____ Sex: _____
 Previous Last Name: _____ Marital Status: S M D W DP
 Occupation: _____ Employer: _____
 Nickname: _____ Spouse Name: _____
 Parent/Legal Guardian Name: _____
 State/Country of Birth: _____ Special Communication Needs: _____

Language: _____ Race: _____ Decline Ethnicity: _____ Decline

Patient Contact Information -

Copy of Driver's License Provided

Address: _____ City: _____
 State: _____ Zip: _____ County: _____ Preferred Phone Number: _____
 Is this phone number? Cell Home Work May we leave detailed messages at this phone? NO YES
 Secondary Phone: _____ Email: _____

Emergency Contact Information -

Name	Relationship	Phone Number	Address

I hereby authorize **Robert A Davis, MD Family Practice** to discuss and or release my PHI (protected health information) to: **Myself Only**

Name	Relationship	Phone

Advanced Care Directive - Do you have an Advance Directive or Living Will? NO YES

Have you designated a Durable Power of Attorney? NO YES *If yes, please enter information below:*

Name	Relationship	Phone Number	Date

Specialist Contact Information - (Please provide first and last names)

	Physician Name	Office Name	Location
Cardiologist:			
Eye Doctor:			
Gynecologist:			
Endocrinologist:			
Urologist:			
Other:			

Robert A Davis, MD Patient Information Form

Patient Information

Account # _____

Legal Name _____ Date of Birth _____
(Last) (First) (Middle)

Mailing Address _____

City _____ State _____ Zip _____

Physical Address (if different from mailing) _____

Home Phone _____ Work Phone _____ Cell Phone _____

Sex: M / F Marital Status: S / M / D / W

Employer _____ City _____

Spouse _____ Spouse DOB _____

If a physician or other medical provider referred you, who referred you _____

Race (circle one): American Indian or Alaskan Native Asian Black or African American
Native Hawaiian or other Pacific Islander White

Ethnicity (circle one): Hispanic or Non Hispanic

Preferred Language (circle one if preferred): English Spanish Other _____

Email address: _____

Preferred Method of contact (circle one): Phone Mail Email

Parent or other Responsible Party if other than patient

Legal Name _____ Date of Birth _____
(Last) (First) (Middle)

Mailing Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Social Security # _____ Sex: M / F Marital Status: S / M / D / W

Employer _____ City _____

Insured Information if Insured Is Not Patient nor Responsible Party

Insured's Name _____ Date of Birth _____

Insured's Social Security # _____

Insured Phone Number _____ Employer _____

.....
Notice of Privacy Practices: I acknowledge I have been offered a copy of Robert A Davis MD Notice of Privacy Practices

Signature _____

(please sign this at check in where you will be given a copy of our Notice of Privacy Practices)

.....
I authorize the staff at Dublin Medical to discuss my medical information with the following persons. This authorization shall remain in effect until such time as it is withdrawn by me in writing.

_____ Relationship _____ Phone _____

_____ Relationship _____ Phone _____

_____ Relationship _____ Phone _____

.....
Emergency Contact Information (must be someone listed above)

Name _____ Phone number(s) _____

Patient Signature: _____ Date: _____

Robert A Davis, MD Family Practice
FINANCIAL POLICY

PATIENT'S PRINTED NAME: _____

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you read and sign prior to any treatment.

- ◆ All patients must complete our Information and Insurance forms before seeing the doctor.
- ◆ FULL PAYMENT OF PATIENT RESPONSIBILITY IS DUE AT TIME OF SERVICE.
- ◆ Insurance cards must be presented at every visit.
- ◆ Not having your insurance card or rebilling for incorrect insurance information will cost you \$15
- ◆ If you have a copay, you are responsible for paying at time of visit.
- ◆ You are responsible for paying your bill within 30 days of receipt.
- ◆ Bills not paid within 30 days, we will add 10% for every 30 days missed for untimely payment.
- ◆ Bills that are sent to collection will cost you an additional \$50
- ◆ Completion of forms, disability, life insurance, school or physical forms will cost \$15
- ◆ All copays, deductibles, and payment of non-covered services are due prior to treatment.
- ◆ We accept cash, checks, credit and debit cards.

If your insurance company has not paid your account in full within 31 days, the balance will be automatically be transferred to you.

Participating

Please be aware that some, and perhaps all, of the services provided may be non-covered services. It is our policy not to perform those services unless deemed medically necessary.

Medical Record Request

We use an outside copying service to complete request for medical records, you must fill out a request to have your medical records copied and sent. Request are picked up by the service on Mondays and the service bills you for the any fees incurred to copy and send your records.

Missed Appointments

Unless canceled 24 hours in advance, unless the cancellation was for an emergency, i.e. hospitalization. Our policy is to charge for missed appointments at the rate of \$ 40 per single missed appointment. Please help us serve you better by keeping scheduled appointments.

- ◆ I acknowledge full responsibility for services rendered by Robert A. Davis, MD Family Practice.
- ◆ I understand that payment of charges incurred is due at time of service unless other financial arrangements have been made prior to treatment.
- ◆ I further authorize and request that payments be made directly to Dublin Medical Center or Robert A Davis, MD.
- ◆ I consent to the release of my health information by Dublin Medical or Robert A. Davis, MD for the purpose of obtaining authorization and payment of services. Your consent does not waive your rights under HIPAA.
- ◆ I have read the Financial Policy, understand it, and agree to the terms of this Financial Policy.

Patients Signature: _____ Date: _____

Date Of Birth : _____

MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to Dublin Medical Center. When you schedule an appointment with our practice, we set aside enough time to provide you with the highest quality care.

Should you need to cancel or rescheduled an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

- Effective May 1, 2019 any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with **at least 24 hours' notice** will be considered a No Show and charged a **\$40.00 fee**.
- Any established patient who fails to show or cancels/reschedules an appointment without 24 hour notice a **second** time will be charged a **\$60.00 fee**.
- If a **third**, No Show or cancellation/reschedule with no 24-hour notice should occur you may be dismissed from the practice.
- Any new patient who fails to show for their initial visit will be contacted to reschedule if they do not keep the second appointment, we will not reschedule again.
- The fee is charged to the patient, not the insurance company, and is **due at the time of the patient's next office visit**.

We understand there may be times when an unforeseen emergency occurs, and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances, please contact our office to discuss.

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

Signature

Printed Name

Staff Witness Signature

Date



DUBLIN MEDICAL CENTER
FAMILY MEDICINE

Dublin Medical Center

Robert A. Davis, M.D.
Joy M Davis, M.S.N., C.R.N.P
Natasha L Worthington, PA-C

174 North Main Street • Dublin PA 18917
Phone: (215) 249-9020 • Fax (215) 249-3469

Notice of Privacy Practices

Patient's Name: _____ (please print)

To our patients: This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA) and Amended March 2013.

Our commitment to your privacy:

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain circumstances:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or to the public. We will only make disclosures to a person or organization able to prevent the threat.
5. If you are a member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For workers Compensation and similar programs.
9. For treatment purposes including sharing medical data with another provider, making referrals, placing lab or prescription orders.
10. For payment purposes, for filing claims either by paper or electronically.
11. For Health care operations, for quality assurance, utilization reviews, credentialing, underwriting and auditing.

Your rights regarding your health information:

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable request.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment if paid out of pocket for certain care or health care operations. Additionally, you have the right to request that we restrict our disclosure for your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when information is necessary to treat you.
3. You have the right to obtain a copy of the health information that may be used to make decisions about you, including patient paper and electronic medical records and billing records, but not including psychotherapy notes. We the practice has 30 days to respond to your request, and to charge an administrative fee of at least \$25.00 for this copay.
4. You must submit your request in writing with the name of your treating physician to the practices Privacy Official, Robert A. Davis M.D, Who can be reached at (215)-249-9020 if you need further information.
5. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as it is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to our practices Privacy Official, Robert A. Davis M.D, Who can be reached at (215)-249-9020 if you need further information.
6. You have the right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact the practices Privacy Official, or her designee at (215)-249-9020
7. Right to file a complaint with our practices Privacy Official or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the practices Privacy Official Robert A. Davis M.D, Who can be reached at (215)-249-9020 if you need further information, All complaints must be submitted in writing. You will not be penalized for filing a complaint.
8. Right to provide an authorization for other uses and disclosures. Our practice will obtain you written authorization for uses and disclosures of Psychotherapy notes, or protected health information that the office uses for Marketing and any other protected health information that are not identified by this notice or permitted by applicable law.
9. You have right to be notified in writing upon a breach of any of your unsecured PHI
10. You have a right to opt out of getting fundraising communications from our office.

Patient Signature: _____ **Date:** _____



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ROBERT A. DAVIS, MD *Family Practice*

Robert A. Davis, MD
Joy M. Davis, MSN, CRNP
Natasha L. Worthington, PA-C

Patient Signature: _____ **Date:** _____

Authorization for Release of Medical Records

Patient Name: _____

Patient Address: _____

Patient DOB: _____

Telephone Number: _____

I authorize the records to disclose/release the following information**(Check all applicable)

- _____ All Records
- _____ Laboratory/Pathology Results
- _____ X-ray/Radiology Records
- _____ Office Notes
- _____ Other: _____

**Note: If these records contain any information about drug/alcohol abuse, sexually transmitted disease, or psychiatric issues, you are hereby authorizing disclosure of this information.

Please release the records FROM:

(Complete name of Person/Organization)

Address

City, State, Zip Code

Phone Number/Fax Number

And send Records TO: Robert A Davis, M.D, Family Practice
P.O Box 450
174 North Main Street
Dublin, PA 18917
Phone: (215)249-9020 Fax: (215)249-3469

By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information.

Signature of patient or patient's representative

Date



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Patient Name: _____ **Date of Birth:** _____

Adult Vaccination/Immunization History - (If available please attach childhood immunizations separately)

	Date		Date		Date
Tetanus		Zoster		Prevnar 13	
TDAP		Shingrix		Pneumovax 23	

Health History - Have you ever been diagnosed with any of the following:

Reconciled

<input type="checkbox"/> Measles/ Mumps	<input type="checkbox"/> Gout	<input type="checkbox"/> Seizures / Epilepsy	<input type="checkbox"/> Bone/Joint Disorder	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Stomach Ulcer	<input type="checkbox"/> Parkinson's Disease	<input type="checkbox"/> Eye Disease	<input type="checkbox"/> Asthma
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Reflux Disease	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Seasonal Allergies
<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Gall Bladder	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Emphysema / COPD
<input type="checkbox"/> Polio	<input type="checkbox"/> Pancreatitis	<input type="checkbox"/> Stroke	<input type="checkbox"/> Kidney Stone	<input type="checkbox"/> Pulmonary Clotting
<input type="checkbox"/> Lyme Disease	<input type="checkbox"/> Colitis	<input type="checkbox"/> Heart Disease / CAD	<input type="checkbox"/> Urinary Disorders	<input type="checkbox"/> Depression
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Diverticulitis	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Erectile Dysfunction	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Irritable Bowel	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Prostate Disease	<input type="checkbox"/> Eating Disorder
<input type="checkbox"/> Sleep Apnea	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Heart Failure	<input type="checkbox"/> Reproductive Issues	<input type="checkbox"/> Psychiatric Care
<input type="checkbox"/> Anemia	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Menstrual Problems	<input type="checkbox"/> Drug Addiction
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Thyroid Disorder	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Vaginal Infection	<input type="checkbox"/> Alcoholism
<input type="checkbox"/> Blood Clot	<input type="checkbox"/> Migraines/Headache	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Breast Lump	<input type="checkbox"/> Sexual Dysfunction
<input type="checkbox"/> Cancer	<input type="checkbox"/> Autoimmune Disease		<input type="checkbox"/> Skin Disease	<input type="checkbox"/> STD
Type:	Type:	Disease	Type:	Type:
Other Health Conditions:				
Blood Transfusion: <input type="checkbox"/> NO <input type="checkbox"/> YES If yes, date: _____ Reason: _____				

FAMILY HISTORY -

Details Attached

Adopted

Reconciled

Relation	Current Age, if living	Age at Death	High Blood Pressure	Heart Disease	Stroke	Cancer	Diabetes	Glaucoma	Asthma	Seizures	Bleeding Disorder
Father			<input type="checkbox"/>								
Mother			<input type="checkbox"/>								
Maternal Grandmother			<input type="checkbox"/>								
Maternal Grandfather			<input type="checkbox"/>								
Paternal Grandmother			<input type="checkbox"/>								
Paternal Grandfather			<input type="checkbox"/>								
Sibling			<input type="checkbox"/>								
Sibling			<input type="checkbox"/>								
Other relative			<input type="checkbox"/>								

Surgical History - None

Details Attached

Reconciled

Procedure	Date

SOCIAL HISTORY - Details Attached

Reconciled

Tobacco Use: <input type="checkbox"/> YES <input type="checkbox"/> NO Cigarettes <input type="checkbox"/> Pipe <input type="checkbox"/> Cigar <input type="checkbox"/> Chew Amount per day: _____ Number of years you have used tobacco: _____ Former tobacco user: <input type="checkbox"/> YES <input type="checkbox"/> NO Last tobacco use: _____	Alcohol Consumption: <input type="checkbox"/> YES <input type="checkbox"/> NO Number of drinks per week: _____ Preferred drink (ie: beer, wine, spirits): _____ _____ <input type="checkbox"/> QUIT Years quit: _____	Recreational Drug Use: <input type="checkbox"/> YES <input type="checkbox"/> NO Type: _____ Amount per week: _____ Last used: _____ <input type="checkbox"/> QUIT Years quit: _____
Caffeine: <input type="checkbox"/> YES <input type="checkbox"/> NO # of caffeine drinks per day: _____	Regular Exercise: <input type="checkbox"/> YES <input type="checkbox"/> NO Type exercise: _____ How often: _____	Do you share a home with anyone else? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Spouse <input type="checkbox"/> Children <input type="checkbox"/> Friend
Are you regularly exposed to second-hand smoke or other potentially harmful substances at home or work? <input type="checkbox"/> YES <input type="checkbox"/> NO If so what? _____	Do you routinely need physical assistance with activities of daily living such as cooking, dressing, hygiene? <input type="checkbox"/> YES <input type="checkbox"/> NO	Are guns kept in your home? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes is gun safety a priority at home? <input type="checkbox"/> YES <input type="checkbox"/> NO
Does everyone in your home receive all routinely recommended immunizations? <input type="checkbox"/> YES <input type="checkbox"/> NO	Is it important to you that you always wear your seatbelt? <input type="checkbox"/> YES <input type="checkbox"/> NO	Do you have working smoke detectors in your home? <input type="checkbox"/> YES <input type="checkbox"/> NO
Do you have regular problems with a lack of enough food in your home? <input type="checkbox"/> YES <input type="checkbox"/> NO	Do you have regular problems with transportation? <input type="checkbox"/> YES <input type="checkbox"/> NO	Do you have regular problems paying for housing? <input type="checkbox"/> YES <input type="checkbox"/> NO
Are you in an abusive relationship or afraid of physical harm from anyone you know? <input type="checkbox"/> YES <input type="checkbox"/> NO	Are you at risk of acquiring HIV infection or other sexually transmitted disease? <input type="checkbox"/> YES <input type="checkbox"/> NO	Do any members of your family have genetically linked health problems?
Do you use e-cigarettes, vape or juul? <input type="checkbox"/> YES <input type="checkbox"/> NO		

Allergies - No Known Drug Allergies

Latex: Yes/No

Reconciled

Over the past two weeks, how often have you been bothered by any of the following? (Check Box)

	Not at All	Several Days	Half the Days	Nearly Every Day
Little interest or pleasure in doing things	0	1	2	3
Feeling depressed or hopeless	0	1	2	3

Wellness Screening History

	Date	Practice/Location Performed	Result
Wellness/Routine Physical Exam			
Colon Cancer Screening			
Mammogram			
Dexa (Bone Density) Scan			
Pap Smear			
PSA			
Full Body Skin Cancer Exam			
Hepatitis C Screening			
Diabetic Eye Exam			

If 65 years or older please answer the following:

Have you felt unsteady or fallen more than once in the past year?	Yes	No <input type="checkbox"/>
Can you switch a light on/off easily from your bed without fear of falling?	Yes	No <input type="checkbox"/>
Are floors and walkways in your home safe and in good repair?	Yes	No
Is it difficult to get out of bed or off a chair or toilet without assistance?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is the lighting in your home sufficient for you to see safely?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Current Medications with Dosages - None

Details Attached

Reconciled

