DUBLIN MEDICAL CENTER
Family Medicine

Patient Information

Patient Information

Last Name	First Name	Middle Initial	Previous Name (If applicable)

Date of Birth	Sex	Social Security #
	☐ Male ☐ Female ☐ Decline	

Marital Status	Spouse Name	Spouse DOB
☐ Single ☐ Married ☐ Divorced ☐ Other		

Race
☐ White ☐ Black or African American
☐ Asian ☐ American Indian / Alaskan Native
☐ Native Hawaiian / Pacific Islander
☐ Prefer not to answer ☐ Other

Ethnicity
☐ Hispanic or Latino ☐ Not Hispanic or Latino
☐ Decline to Answer

Preferred Language
☐ English ☐ Español ☐ Other _____

Employer	Occupation

Contact Information

Mailing Address	Apt #	City	State	Zip Code

Cell Phone ☐ Preferred	Home Phone ☐ Preferred	Work Email ☐ Preferred

Email Address	Preferred Contact Method	Can we leave you a voice message?
	☐ Phone ☐ Email ☐ Mail	☐ Yes ☐ No

Insurance

Primary Insurance		Secondary Insurance	
Insurance Company Name		Insurance Company Name	
Policy Holder Name		Policy Holder Name	
Policy Name / Member Id	Group Id	Policy Name / Member Id	Group Id
Policy Holder DOB	Policy Holder SS#	Policy Holder DOB	Policy Holder SS#
Patient Relationship to Policy Holder ☐ Self ☐ Spouse ☐ Dependent		Patient Relationship to Policy Holder ☐ Self ☐ Spouse ☐ Dependent	

Parent / Guardian / Responsible Party (If other than patient)

Last Name	First Name	Middle Initial	Relationship to Patient

Date of Birth	Sex	Social Security #
	☐ Male ☐ Female ☐ Decline	

Mailing Address	Apt #	City	State	Zip Code

Cell Phone	Home Phone	Work Email
☐ Preferred	☐ Preferred	☐ Preferred

Emergency Contact

Contact Name	Relationship to Patient	Phone Number

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

☐ Do not discuss my health with anyone but me or my designated responsible party.

Contact Name	Relationship to Patient	Phone Number

I voluntarily consent to any and all health care treatment and diagnostic procedures provided by Robert A Davis, MD Family Practice and its associated physicians, clinicians and other personnel. I am aware that the practice of medicine and other health care professions is not an exact science and I further state that I understand that no guarantee has been or can be made as to the results of the treatments or examinations at Robert A Davis, MD Family Practice.

I authorize the payment of medical benefits to Robert A Davis, MD Family Practice or their designated partner for services rendered.

I have received a copy of both the Notice of Privacy Policy, Financial Policy, and Medical Appointment Cancellation / No Show Policy.

Sign Your Name: _____ **Date:** _____

Print Your Name: _____ **Date of Birth:** _____

145 N Main St, Suite 200
Dublin, PA 18917

P.O. Box 450
Dublin, PA 18917

Telephone: 215-249-9020 | Fax: 215-249-3469

DUBLIN MEDICAL CENTER
Family Medicine

Medical History & Care Information

Patient Name: _____ **Date:** _____

Care Directives

Do you have an Advance Directive or Living Will?	Have you designated a Durable Power of Attorney?
☐ Yes ☐ No	☐ Yes ☐ No

Durable Power of Attorney Information

Contact Name	Relationship to Patient	Phone Number	Date

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

Tetanus	Date	Zoster	Date	Prevnar 13	Date
TDAP	Date	Shingrix	Date	Pneumovax 23	Date
COVID-19	Date	Which Vaccine Did You Receive? ☐ Pfizer ☐ Moderna ☐ Johnson & Johnson ☐ AstraZeneca			

Specialist Contact Info

Provider	Office Name	Phone Number	Additional Info
Provider	Office Name	Phone Number	Additional Info
Provider	Office Name	Phone Number	Additional Info

Allergies

Enter all allergies that you are aware of

Health History - Have you ever been diagnosed with any of the following:							Circle All that Apply
Alcoholism	Anemia	Anxiety	Arthritis	Asthma	Autoimmune Disease	Bleeding Disorder	Blood Clot
Bone / Joint Disorder	Breast Lump	Cancer	Chicken Pox	Colitis	Depression	Diabetes	Diverticulitis
Drug Addiction	Eating Disorder	Emphysema / COPD	Erectile Dysfunction	Eye Disease	Gall Bladder	Glaucoma	Gout
Heart Attack	Heart Disease / CAD	Heart Failure	Heart Murmur	Hepatitis	High Blood Pressure	High Cholesterol	Irritable Bowel Syndrome (IBS)
Kidney Disease	Kidney Stone	Liver Disease	Lyme Disease	Measles / Mumps	Menstrual Problems	Migraines / Headaches	Multiple Sclerosis
Osteoporosis	Pancreatitis	Parkinson's Disease	Pneumonia	Polio	Prostate Disease	Psychiatric Care	Pulmonary Clotting
Reflux Disease	Reproductive Issues	Rheumatic Fever	Scarlet Fever	Seasonal Allergies	Seizures / Epilepsy	Shortness of Breath	Sexual Dysfunction
Skin Disease	Sleep Apnea	STDs	Stomach Ulcer	Stroke	Thyroid Disorder	Tiredness	Tuberculosis
Urinary Disorders	Vaginal Infection	Other: _____					

Family History

Relation	Current Age, if living	Age at Death	High Blood Pressure	Heart Disease	Stroke	Cancer	Diabetes	Glaucoma	Asthma	Seizures	Bleeding Disorder
Father			☐	☐	☐	☐	☐	☐	☐	☐	☐
Mother			☐	☐	☐	☐	☐	☐	☐	☐	☐
Maternal Grandmother			☐	☐	☐	☐	☐	☐	☐	☐	☐
Maternal Grandfather			☐	☐	☐	☐	☐	☐	☐	☐	☐
Paternal Grandmother			☐	☐	☐	☐	☐	☐	☐	☐	☐
Paternal Grandfather			☐	☐	☐	☐	☐	☐	☐	☐	☐
Sibling			☐	☐	☐	☐	☐	☐	☐	☐	☐
Sibling			☐	☐	☐	☐	☐	☐	☐	☐	☐
Other Relative			☐	☐	☐	☐	☐	☐	☐	☐	☐

Social History

Tobacco

Do you use? ☐ Yes ☐ No

☐ Cigarettes ☐ Pipe ☐ Cigar ☐ Chew

Have you quit or are you a former user? ☐ Yes ☐ No

# of Yrs	Amount per day	Last use

Alcohol

Do you use? ☐ Yes ☐ No

Preferred Drink (i.e. wine, beer, etc)	Have you quit or are you a former user? ☐ Yes ☐ No

# of Yrs	Amount per week	Last use

Caffeine

Do you use? ☐ Yes ☐ No

# of caffeine drinks per day

Exercise

Do you get regular exercise? ☐ Yes ☐ No

Type of Exercise?

How often?

Secondhand Exposure

Are you regularly exposed to second-hand smoke or other potentially harmful substances at home or work? ☐ Yes ☐ No

If so, what?

Recreational Drugs

Do you use? ☐ Yes ☐ No

Type of Substance	Have you quit or are you a former user? ☐ Yes ☐ No

# of Yrs	Amount per week	Last use

Do you use e-cigarettes, vape or juul? ☐ Yes ☐ No

Do you routinely need physical assistance with activities of daily living such as cooking, dressing, hygiene? ☐ Yes ☐ No

Do any members of your family have genetically linked health problems? ☐ Yes ☐ No

Over the past two weeks, how often have you been bothered by any of the following? Circle the Best Option

	Not At All	Some Days	Several Days	Half the Days	Almost Every Day
Little interest or pleasure in doing things	1	2	3	4	5
Feeling depressed or hopeless	1	2	3	4	5

If 65 years or older, please answer the following:

Have you felt unsteady or fallen more than once in the past year?	☐ Yes	☐ No
Can you switch a light on/off easily from your bed without fear of falling?	☐ Yes	☐ No
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	☐ No
Is the lighting in your home sufficient for you to see?	☐ Yes	☐ No

Current Medications		
Medication	Dosage	Reason for Taking (optional)
Medication	Dosage	Reason for Taking (optional)
Medication	Dosage	Reason for Taking (optional)
Medication	Dosage	Reason for Taking (optional)
Medication	Dosage	Reason for Taking (optional)
Medication	Dosage	Reason for Taking (optional)
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Medication	Dosage	Reason for Taking (optional)
Medication	Dosage	Reason for Taking (optional)
Medication	Dosage	Reason for Taking (optional)

DUBLIN MEDICAL CENTER

FAMILY MEDICINE

Robert Davis, MD | Joy Davis, CRNP | Natasha Worthington, PA-C

www.Dublin-Medical.com

Authorization for Request of Medical Records

Patient Information				
Last Name	First Name	Middle Initial	Previous Name (If applicable)	
Mailing Address	Apt #	City	State	Zip Code
Date of Birth	Phone Number	Email Address		

I authorize my medical records to be disclosed / released.	Please Initial	
Include last three (3) years of records, including lifetime record of vaccinations, last ten (10) years of colon cancer screenings, and last three (3) years of Labs, Radiology, Mammograms, and any other relevant testing	☐ Yes	☐ No

**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 my records from:				
Organization Name				
Address	Apt #	City	State	Zip Code
Phone Number	Fax Number	Email Address		

Please send records to:

Robert A Davis, M.D, Family Practice

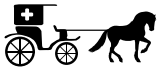
P.O. Box 450

145 North Main St,

Dublin, PA 18917

Phone: (215) 249-9020 | Fax: (215) 249-3469

Email: Office@Dublin-Medical.com



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.

Patient or Representative's Signature

Date

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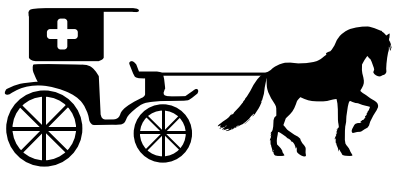
Authorization for Release of Medical Records

Patient Information				
Last Name	First Name		Middle Initial	Previous Name (If applicable)
Mailing Address		Apt #	City	State / Zip Code
Date of Birth	Phone Number		Email Address	

I authorize the below medical records to be disclosed / released.				Please Initial
☐ All Records	☐ Lab / 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 my records to:				
Organization Name				
Address		Apt #	City	State / Zip Code
Phone Number	Fax Number		Email Address	



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.

Patient or Representative's Signature

Date

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FAMILY MEDICINE

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Acknowledgment of Practice Policies

I, _____ , hereby acknowledge that I have received, reviewed, and agree to
Print Patient's First and Last Name

the policies outlined in the following documents:

Medical Appointment Cancellation / No Show Policy:

_____ _____

Patient or Representative's Signature **Date**

Financial Policy

_____ _____

Patient or Representative's Signature **Date**

Notice of Privacy Practice (HIPPA)

_____ _____

Patient or Representative's Signature **Date**

Thank you for reviewing our policies.

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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.

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Financial Policy

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 collections will cost you an additional $50
- 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 requests for medical records. You must fill out a request to have your medical records copied and sent. Requests 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 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.

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Notice of Privacy Practices

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:

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 Worker's 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.

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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 practice's 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 practice's Privacy Official, Robert A. Davis M.D, or his 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 your 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.

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Notice of Visit Billing Policy

If you are here for a scheduled preventive medicine visit (i.e. well-visit, preventive exam or yearly physical exam), this visit will be submitted as a preventive exam to your insurance.

If you are here for a CDL visit, this type of examination is not covered by insurance. If during this visit you are seen for a medical condition that falls outside the scope of the annual well visit, your insurance will be billed.

Depending on your health plan's policy, your insurance may or may not cover this visit. Not all insurance companies cover well visits or you may have a maximum annual cap for well benefits that is less than our charges.

If during the course of your annual well exam, the physician addresses and documents a problem-related issue (i.e. hypertension, depression, diabetes, pain, etc.), you may also receive an office visit charge as well. In addition, your insurance may require you to pay a co-pays for today's visit because of the well-visit and a problem-visit charge on the same day.

Some health plans have forced us to schedule the physical on a different day than the well-woman (annual female exam with pap), due to the fact that they will not pay for both on the same day. Please be assured that we understand that this is not convenient for our patients. We are sorry for the inconvenience.

Lastly, the provider assigns codes according to the services they provide. The provider cannot alter the coding submitted to your insurance in order for your insurance carrier to make payment.

If you have any questions, please contact our billing department.

Please sign below acknowledging that you have read and understand this information.

Patient or Representative's Signature **Date**

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