PATIENT REGISTRATION

HOW DID YOU HEAR ABOUT US: _____

Name: _____ Date: ____/____/____
(First, Middle, Last)

Age: _____ Sex _____ Birthday ____/____/____ SS Number: _____

Email Address: _____ *May we contact you via email?* Yes____ No____

Local Street Address _____

City/State/Zip _____ Phone _____

Northern Address _____

City/State/Zip _____ Phone _____

____Divorced ____Legally Separated ____Married ____Single ____Widowed

Race _____ Primary Language _____

RESPONSIBLE PARTY INFORMATION (If different from patient)

Name _____ Date____/____/____ Home Phone _____

Age_____ Sex_____ Birthday____/____/____ SS Number _____

Permanent Street Address _____ City/State/Zip _____

EMPLOYMENT INFORMATION

Employer _____

Address/Phone _____

INSURANCE INFORMATION

Primary: _____
(Name of Insurance) (Member Number)

Secondary _____
(Name of Insurance) (Member Number)

EMERGENCY NOTIFICATION:

_____ _____ _____
(Name) (Phone Number) (Relationship)

Phillip G. Davis, M.D.
7560 Winkler Road | Fort Myers, FL 33908 | Phone: (239) 454-6868 | Fax: (239) 466-5254

Medical History

Why have you come to see the doctor? _____

Do you have any other concerns you'd like to address? _____

How is your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

List Medications & Doses: _____

_____

_____

_____

Are you allergic to any kinds of medications, drugs or other things? ☐ Yes ☐ No
If yes, please list below what you are allergic to and what kind of reaction you have had: _____

_____

_____

Have you ever been hospitalized or had surgery? ☐ Yes ☐ No If yes, please list them below:

_____

_____

Past Medical History

☐ Alcoholism	☐ Anemia	☐ Asthma	☐ Bleeding Disorder	☐ Cancer	☐ Diabetes
☐ Depression	☐ Epilepsy	☐ Heart Disease	☐ Hepatitis A, B, or C	☐ High Blood Pressure	
☐ High Cholesterol	☐ Osteoporosis	☐ Stroke	☐ Substance Abuse	☐ Thyroid Disorder	

Lifestyle Factors

Do you smoke tobacco?	☐ Yes ☐ No	If yes, packs/day? _____	☐ Social ☐ Former
Do you drink alcohol?	☐ Yes ☐ No	If yes, how much in one day?	_____
Do you drink coffee/tea?	☐ Yes ☐ No	If yes, how much in one day?	_____
Do you exercise?	☐ Yes ☐ No	If yes, how often in a week?	_____
Do you use drugs?	☐ Yes ☐ No	If yes, what kind, and how much?	_____
Changes in your weight recently?	☐ Yes ☐ No	If yes, how much?	_____
Are you sexually active?	☐ Yes ☐ No	If yes, how many partners in the past year?	_____

Have any of your family had any of the diseases listed below?

Cancer	☐ Yes ☐ No	If yes, who? _____
Tuberculosis	☐ Yes ☐ No	If yes, who? _____
Diabetes	☐ Yes ☐ No	If yes, who? _____
High Blood Pressure	☐ Yes ☐ No	If yes, who? _____
Heart Attack	☐ Yes ☐ No	If yes, who? _____
Stroke	☐ Yes ☐ No	If yes, who? _____
Epilepsy	☐ Yes ☐ No	If yes, who? _____

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Name: DOB:

Phillip Davis, MD

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Fort Myers, FL 33908
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Fax: 239-466-5254

Our goal is to provide quality medical care in a timely manner. In order to do so, we have had to implement a cancellation/ no-show policy. This policy enables us to better utilize available appointments for our patients in need medical care.

Cancellation of an appointment:
In order to be respectful of the medical needs of other patients, please be courteous and notify us promptly if you are unable to attend an appointment. This time will be reallocated to someone who needs treatment. If it's necessary to cancel your scheduled appointment, we ask that you call 24 hours in advance, and calling early in the day is appreciated. Appointments are in demand, and your early cancellation will give another person the possibility to have access to timely medical care.

Ways we confirm appointments:
Confirmation calls are given as a courtesy to remind you of your appointment. Ultimately it is not our responsibility to make a patient remember their appointment. We call two business days in advance and can also offer email confirmations three business days in advance. If you would like to receive email confirmations, please be sure to notify someone at the front desk so they can verify your email and activate for confirmation of appointments.

How to cancel your appointment:
To cancel appointments, please call **239-454-6868** between the hours of Monday through Friday, 8a to 12pm and 1pm to 5pm. We do not have an answering service.

No-Show Policy

Definition
A "no-show" is also considered a "missed appointment" this occurs when you fail to show up for an appointment without a phone call.

Policy
A failure to present at the time of scheduled appointment will be recorded in your chart as a "no-show" and a fee of **$75.00** will be charged to your patient account. After the third "no-show" you will be subject to possible discharge from our practice.

Your signature indicates that you have read and understand our Cancellation/No-Show Policy.

_____ ____/____/____
Patient Name (print) DOB

_____ ____/____/____
Patient Signature Date

Effective 01/18/2018

Phillip G. Davis, M.D.

PERMISSION TO RELEASE INFORMATION

I hereby grant the staff at Phillip G. Davis, M.D. Permission to release medical information about me to the following:

Name:_____ Phone:_____ Relationship:_____

Name:_____ Phone:_____ Relationship:_____

Name:_____ Phone:_____ Relationship:_____

Name:_____ Phone:_____ Relationship:_____

Name:_____ Phone:_____ Relationship:_____

Name:_____ Phone:_____ Relationship:_____

This release will remain in effect until revoked in writing by the undersigned.

_____ Date:_____
Patient Signature

_____ Date of Birth: _____
Patient Name (PLEASE PRINT)

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Phillip G. Davis, MD
7560 Winkler Rd
Fort Myers, FL 33908
Ph: 239-454-6868 / F: 239-466-5254

Date: _____ / _____ / _____

Patient Name: _____ DOB: _____ / _____ / _____

To ensure that we are providing the best quality care for you, we need to have update pharmacy information. Please provide us with your:

Local Pharmacy Name: _____

Local Pharmacy Phone Number: (_____) _____

Mail-in Pharmacy Name: _____

****Please let us know if this information ever changes so that we can keep your records up to date****

Medication list:

Phillip G. Davis, M.D.

Insurance & Payment Information

Insurance members:

- If you are enrolled in a insurance, in which our office participates, (it is your responsibility to know if Dr. Davis is on your plan), a claim will be filed from our office for services rendered. You will be responsible for any deductible, co-payments, co-insurance and non-covered services according to the terms of your insurance contract.
- If you are enrolled in HMO, in which our office participates, your co-payment is required at the time of service. You are responsible to give us a current authorization before being seen otherwise payment is expected at the time of service.
- If our office has not received payment from your carrier within 90 days, you, the patient will be notified and responsible for payment. Our agreement is with you, not your insurance company. Although we will assist you by submitting the claim to your carrier, you are ultimately responsible for the services you receive. Payment to our office is not contingent or dependent upon you insurance coverage.

Payment Methods:
Our office accepts cash, money orders, personal checks, Debit Cards, Visa & Mastercard. Returned checks will receive a $25.00 overdraft protection charge.

How will you be paying today? Cash Check Credit Card

Lifetime Guarantee/Authorization, Privacy Practice Acknowledgment, Release of Information

- I understand that I am fully and legally responsible for all billing charges of this account which includes all outstanding balances not covered by Medicare and/or insurance companies. I understand that physicals and tetanus shots are not covered by Medicare. In the event that I fail to pay any outstanding balance, I also agree to pay all costs of collection agency fees, attorney's fees and court costs, if any.
- I acknowledge that I have received or been offered a copy of the Notice of Privacy Practices for the medical office of Phillip G. Davis, M.D.
- I give the office of Phillip G. Davis, M.D. permission to release my medical records to any physician/facility I am referred to an also to my insurance company for payment.

_____ _____

Signature Date

Phillip G. Davis, MD
7560 Winkler Rd
Fort Myers, FL 33908
Ph: 239-454-6868 / Fax: 239-466-5254

Patient Name: _____ **DOB:** _____/_____/_____

When was your **LAST**...

Colonoscopy _____/_____/_____

Who was the ordering Provider? _____

Where was the test performed? _____

Eye Exam _____/_____/_____

Who was the ordering Provider? _____

Where was the test performed? _____

Mammogram _____/_____/_____

Who was the ordering Provider? _____

Where was the test performed? _____

Dexa Scan _____/_____/_____

Who was the ordering Provider? _____

Where was the test performed? _____

Physicians signature: _____