



PATIENT REGISTRATION FORM

PATIENT INFORMATION: THIS SECTION REFERS TO THE PATIENT ONLY

Last Name: _____ First Name: _____ MI: _____

Social Security Number: _____ Address: _____

Address cont (apt. #, lot #, etc) _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Sex: Male Female Marital Status: Married Single Divorced Widowed

Home phone: (_____) _____ cell phone: (_____) _____ work phone: (_____) _____

Best daytime number to reach you: home work cell Is it ok to leave a message at any of the numbers? Yes No

If no, please designate which ones, if any: _____

Primary Care Physician's Name (if applicable): _____ How did you hear about us? _____

Spouse's Name: _____ Date of Birth: _____ Spouse's SS#: _____

RESPONSIBLE PARTY: THIS SECTION REFERS TO THE PERSON/PARTY WHO SHOULD RECEIVE THE BILL

Relationship to Patient: Self (skip to next section) Parent Spouse Other (skip to next section) _____

Last Name: _____ First Name: _____ MI: _____

Social Security Number: _____ Birth date (mm/dd/yyyy): _____ Sex: Male Female

Address: _____ City: _____ State: _____ Zip: _____

Home phone: (_____) _____ Cell phone: (_____) _____ Work phone: (_____) _____

INSURANCE INFORMATION

Primary Insurance Coverage: _____ Copay: \$ _____

Policy effective date: _____ Deductible: \$ _____ Met? Yes No If no, amount met: \$ _____

Address: _____ City: _____ State: _____ Zip: _____

Policy Number: _____ Group Number: _____ Subscriber: _____

Subscriber's DOB: _____ Subscriber's SS #: _____

Secondary Insurance Coverage: _____

Address: _____ City: _____ State: _____ Zip: _____

Policy Number: _____ Group Number: _____ Subscriber: _____

Subscriber's DOB: _____ Subscriber's SS #: _____

Verified Patient Information Staff Initials: _____

DISCLOSURE TO FAMILIES AND LOVED ONES (Emergency Contacts)

I authorize Baptist Medical Group, to disclose my health care information and to discuss my health care needs to those that I designate. I further authorize the release of my billing information and give these individuals the ability to pick up prescriptions and/or medications on my behalf. These individuals will be considered my emergency contacts. Without authorization, no information may be shared. I authorize Baptist Medical Group to disclose my personal health information to the following people:

Name: _____ Relationship: _____ Phone: (____) _____

Name: _____ Relationship: _____ Phone: (____) _____

Name: _____ Relationship: _____ Phone: (____) _____

CONSENT TO TREATMENT FOR ALL PATIENTS

I hereby grant authorization and consent for medical treatment and/or procedures for myself or the patient for whom I am the parent or legally authorized representative for which I am signing for, and understand that no guarantee or assurance has been made as to the results for which may be obtained.

Patient initials

PHOTO DOCUMENTATION

I hereby grant authorization for the clerical staff to make a copy of my photo identification to be included in my confidential record as well as take a digital picture for additional protection against the theft of my medical identity. I further grant authorization for the clinical staff to take photo documentation of any injury or procedure that they feel is medically necessary to include in my confidential medical record.

Patient initials

NOTICE OF PRIVACY PRACTICES

I received a copy of the Baptist Health Care "Notice of Privacy Practices" today and agree with these privacy policies.

Patient initials

INSURANCE ASSIGNMENT AND FINANCIAL RESPONSIBILITY

I hereby authorize the offices of Baptist Medical Group (BMG), to release any medical information required during the course of examination and treatment to my insurance company, and I permit payment to BMG from my insurance for any benefits due for their services rendered. I recognize and accept responsibility for services rendered regardless of insurance coverage. This includes but is not limited to coinsurance, copayment, deductible and non-covered services.

I understand that I am responsible for all charges incurred regardless of the insurance status. I agree to pay for services incurred after the patient has been charged for the office visit, such as labs, radiology, medical supplies, etc. I agree to pay my bill in full for services rendered by Baptist Medical Group providers.

Patient initials

Date

Signature of Patient or Guardian if patient is Minor

Patient Name: _____ DOB: _____



PATIENT HISTORY FORM

Place a check beside any medical problem (s) you have had in the past or may currently have.
Place a check beside any medical problem (s) any family member has had in the past or may currently have.

PATIENT AND FAMILY

	Patient	Family	Year		Patient	Family	Year
Anemia				Immune Deficiency			
Arthritis				Liver Disease			
Heart Arrhythmia/Palpitations				Kidney Disease			
Asthma				Neuropathy			
Bleeding Problems				Paralysis			
Blood Clots				Peripheral Vascular Disease			
Cancer: Type _____				Pneumonia			
Chest Pain/Angina				Psychiatric Illness			
Diabetes				Pulmonary Embolism			
Gall Bladder disease				Reflux			
Gastric Ulcers				Skin ulcer/breakdown			
Glaucoma / Loss of Vision				Steroid Use			
Heart Attack				Stroke			
Heart Failure				Thyroid Disease			
Heart Murmur				Tuberculosis (TB)			
Hepatitis B / Hepatitis C				Urinary Infections			
High Blood Pressure				Valve Disorders (Heart)			
HIV/AIDS				Wound Healing Problems			

List any medical problem(s) not listed above: _____

Are you experiencing any of the above problem(s) today? Yes No If Yes, when did symptoms begin? _____

If you checked yes, please explain: _____

Please check if you have any allergies: Yes No If yes, please list: _____

Please check if you have any medication allergies: Yes No If yes, please list: _____

Please list current medication(s) below: _____ Dosage _____ Physician _____ _____ Dosage _____ Physician _____ _____ Dosage _____ Physician _____	_____ Dosage _____ Physician _____ _____ Dosage _____ Physician _____ _____ Dosage _____ Physician _____
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Please list any surgeries you have had below and, if possible, physician(s) and date (s).

_____ Physician: _____ Date: _____

_____ Physician: _____ Date: _____

_____ Physician: _____ Date: _____

_____ Physician: _____ Date: _____

SOCIAL HISTORY

Alcohol? Yes No If yes, drinks per week: _____ Smoking/Tobacco? Yes No If yes, Packs/day: _____ Years _____

History of Illicit Drug Abuse? Yes No If yes, kind(s) of drug: _____ Frequency: _____

Smokeless Tobacco? Yes No Frequency: _____ Daily caffeine intake (coffee, tea, sodas)? _____

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____