BAPTIST HOSPITAL, INC. – CONSENT FOR TREATMENT AND CONDITIONS OF ADMISSION

1. Medical and Surgical Consent.

   a. I recognize that I have a condition requiring medical care, and I hereby consent to such medical care and treatment and such diagnostic tests at Baptist Hospital, Inc. (the “Hospital”), as the physicians and staff at the Hospital may deem necessary or advisable. I hereby consent to photographs, videos, digital images that may be recorded to document my care, any x-ray examination, laboratory procedures, urine drug screen, blood drug screen, anesthesia, medical, surgical or dental treatment or Hospital services rendered to me under the general and special instructions of the physician/dentist.

   b. I understand that if I am pregnant, my physician may determine that it is necessary to take urine or blood samples to perform drug screens, and I consent to both the taking of the samples and the performance of the screens.

   c. I understand and acknowledge that this facility participates in the education of health care personnel and that students may be involved in the care I receive.

   d. I understand that an explanation of the risks, benefits and alternatives of any medical or surgical procedure performed by my physician will be explained to me by my physician except in an emergency situation.

   e. I UNDERSTAND AND AGREE THAT, AS A PATIENT, MY ATTENDING PHYSICIAN IS DIRECTING MY CARE, AND I RECOGNIZE THAT NONE OF THE PHYSICIANS PROVIDING CARE TO ME INCLUDING, BUT NOT LIMITED TO, EMERGENCY ROOM PHYSICIANS, SURGEONS, RADIOLOGISTS, PATHOLOGISTS AND ANESTHESIOLOGISTS, ARE EMPLOYED BY THE HOSPITAL. PHYSICIANS HAVE PERMISSION TO USE THE HOSPITAL FACILITIES AND MAY TAKE EMERGENCY CALLS FOR THE HOSPITAL BUT ARE INDEPENDENT CONTRACTORS AND NOT AGENTS OR EMPLOYEES OF THE HOSPITAL EVEN THOUGH THEY MAY WEAR GARMENTS OR IDENTIFICATION THAT INCLUDE THE HOSPITAL’S NAME OR LOGO. **I EXPRESSLY AGREE TO RELEASE AND DISCHARGE THE DUTY OF THE HOSPITAL AS TO SERVICES THAT MAY BE PERFORMED BY PHYSICIANS WHO ARE INDEPENDENT CONTRACTORS, BUT NOT EMPLOYEES, OF THE HOSPITAL. I UNDERSTAND THAT BY RELEASING AND DISCHARGING THE HOSPITAL OF ITS DUTY AS TO THESE SERVICES, I AM GIVING UP THE RIGHT TO HOLD THE HOSPITAL LIABLE FOR THE POTENTIAL NEGLIGENCE OF THE PHYSICIANS.**

2. Release of Information. I authorize the Hospital to disclose all or any part of my record, including my medical records, to any person or entity that may be liable to the Hospital or me for all or part of the Hospital’s charges, including, but not limited to: a) hospital or medical service companies; b) insurance companies; c) workers’ compensation carriers; d) welfare or social services agencies; e) my employer; f) any entity that provides pharmaceutical products or services to the Hospital for my benefit and that offers reimbursement to the Hospital for the provision of those products and services. All such disclosures will be conducted in accordance with applicable laws. I further agree to release the Hospital, its employees, agents and assigns, and representatives from any and all liability arising out of the release of my records pursuant to this paragraph.

3. Consent for Testing and Sharing of Test Results. If, in the course of my medical care, a health care worker is exposed to my blood or other bodily fluids, I give consent for a sample of my blood to be tested for HIV or Hepatitis B antibodies. I understand and acknowledge that the health care worker will be notified of the results for purposes of his or her treatment. I will also be notified of the results.

4. Personal Valuables. I understand the Hospital is not responsible for the safekeeping of my personal belongings such as money, jewelry, dentures, hearing aids, eyeglasses, watches, credit cards, or phones.

5. Assignment of Insurance Benefits. I assign payment of all applicable insurance payments directly to the Hospital and agree that the Hospital may receive any such payment, and I further understand and agree that I will be responsible for charges

6. Medicare-Medicaid Patients Certification. I certify that the information given by me in applying for payment under Titles XVIII and XIX of the Social Security Act is correct. I authorize the release of all records, including but not limited to medical records. required to act on this request and that payment of authorized benefits be made directly to the Hospital and the physicians involved in my care for any services furnished me by the Hospital and said physicians.

7. Indigent Drug Program. If I qualify and accept assistance, I agree to comply with the policies of the Hospital's drug program for indigents, which may provide me with replacement of certain medications.

8. Patient Information Packet. I acknowledge that I have been offered Hospital's Patient Admission Packet, which includes the notice of patients' rights and the Notice of Privacy Practices.

9. Emergency Care. I understand that if I come to the Hospital's dedicated emergency department seeking care, I will be screened for an emergency medical condition and, if I have an emergency medical condition, the Hospital will provide stabilizing treatment, admit me to the Hospital as an inpatient, or transfer me if medically needed. The screening and the stabilization will be provided **regardless of my ability to pay.** I certify that the Hospital has not withheld, delayed, or conditioned screening or stabilizing care based upon my signing or refusing to sign this paragraph or based upon any payment related concerns.

10. Obligation to Pay My Hospital Bill. I acknowledge that I am financially responsible for my Hospital bills (or, if signed by a guarantor, the guarantor is responsible) which are not paid for by my health insurance, and I agree to pay them promptly. If my insurance does not pay my claim after reasonable attempts by the Hospital, I may be responsible for paying my entire bill to the Hospital.

11. Financial Assistance. **I understand the Hospital has financial assistance programs available to those individuals who are unable to pay for their care, based upon a determination of financial need.** By signing below, I acknowledge that the Hospital's financial assistance policy is available to me on the Hospital's webpage or, will be made available to me upon request from the person who provided me this form. I understand I may be asked to provide my personal financial information and/or submit to a credit check in order to qualify for the financial assistance program. If I do not qualify for a financial assistance program, I understand that I may be able to enter into a payment plan with the Hospital.

12. Patient Contact. I authorize the Hospital, its service providers (including service providers contacting me about obtaining potential financial assistance for my account(s) and/or for collection services) and their successors, assigns, affiliates, or agents to contact me at any telephone number associated with my account(s), including wireless telephone numbers or other numbers that result in charges to me, whether provided in the past, present or future. I agree that methods of contact may include using prerecorded or artificial voice messages and/or an automatic telephone dialing system, as applicable.

____

Patient or Patient's Representative (if patient is minor or unable to sign) Relationship to Patient Date and Time

____

Witness

If patient is a minor, the parent must also complete the following:

The undersigned guarantees and agrees to pay to the Hospital on demand for any and all indebtedness of the patient to the Hospital relating to services provided pursuant to this consent form.

____

Guarantor Date and Time

____

Guarantor (Print Name)

Revised 6/2019

Baptist Medical Group
Patient Consent and Responsibility Agreement

Welcome to Baptist Medical Group (BMG). We understand you have many choices when it comes to health care and we are glad you chose our medical group. We look forward to providing you with quality health care that is accessible, comprehensive, team-based, coordinated, and focused on your health and safety. Please review the following patient responsibilities, sign and return.

CONSENT FOR TREATMENT. I consent to all services as ordered or performed by my BMG physician, advanced practice provider, or their assistants and designees. This care may include, but is not limited to, medical examination and treatment, administration of drugs or vaccines, nursing care, laboratory, and x-ray procedures. I understand that the practice of medicine is not an exact science and I acknowledge that no guarantees or promises have been made to me about the results of any treatment.

OBLIGATION TO PAY MY BMG BILL: I understand that all charges for services rendered are due and payable at the time of service. If I have health care insurance, I agree to pay for any deductibles, co-payments and the patient responsibility portion of the fee at the time of service. I acknowledge that I am financially responsible for my provider bills (or, if signed by a guarantor, the guarantor is responsible) which are not paid for by a third party payor, and I agree to pay the bill promptly.

MEDICAL INSURANCE: I authorize BMG to bill my health plan or other applicable insurer or third party payor and I assign to BMG all of my rights and claims for reimbursement by a third party payor. I authorize BMG to release to all third party payors any medical information that is required in order for BMG to receive payment for its services to me. I will inform my provider of any changes in address or phone number for myself and/or responsible party, present my photo ID and all insurance identification cards upon request. I understand I may be responsible for the entire provider bill if my third party payor refuses to pay after reasonable attempts to collect from the third party payor.

APPOINTMENTS: I agree to bring a list of all medications I am currently taking to each appointment. I agree to check in on time for my appointment. I understand that if I am late for my appointment, I will be rescheduled for the next available appointment time and understand there may not be an appointment available the same day. I agree to notify the office at least 24 hours in advance of my appointment if I find I must cancel my appointment. I understand that failure to notify the office 24 hours in advance may result in a $25.00 missed appointment fee, which cannot be billed to insurance. I understand my patient/physician relationship may be terminated if I miss more than three appointments.

AUTHORIZATIONS AND REFERRALS: I understand that I am responsible for notifying the practice if my third party payor requires pre-authorizations for tests or for referrals to specialists. I understand the BMG office staff may assist me with scheduling referrals or diagnostic testing, but failure to obtain necessary authorizations before the scheduled appointment may result in the visit/test needing to be rescheduled and/or charges being billed directly to me.

FINANCIAL ASSISTANCE: I understand there are financial assistance programs available for patients who are unable to pay for their care based upon a determination of financial need in accordance with Baptist Health Care's Financial Assistance Policy. I understand it is my responsibility to contact a Patient Account Specialist at BMG's business office at (850) 469-2000 to request financial assistance or access the policy and application at https://ebaptisthealthcare.org/PatientFinancialResources. I agree to provide my personal financial information and/or submit to a credit check to determine if I qualify for financial assistance. If I do not qualify for financial assistance and do not have insurance third party payor, I understand and agree that I will pay in full for all services at the time of service. If I do not have insurance, I may be eligible for a discount when full payment is made at time of service.

RETURN CHECK POLICY: I understand I will be responsible for all service charges and collection fees associated with collecting any bad check I write, and will pay these fees upon notice.

BUSINESS HOURS: I understand unusual circumstances will sometimes require the office hours to be changed without notice. I understand the pre-recorded telephone message will let me know when to call back for routine requests and what to do in case of an urgent medical need (one that does not require emergency treatment). I understand that I should call 911 in the event of a medical emergency or proceed to the closest emergency room for treatment.

PRESCRIPTIONS AND/OR REFILLS: I understand that requests for new medication and/or refills should be made during my visit with my provider. If I need a prescription refill between visits, I agree to contact the practice or my pharmacy and allow 48 to 72 business hours to process. I understand refill requests will only be processed during office hours. I understand that narcotic prescriptions are highly regulated and may require a signed narcotics agreement between me and my provider.

PATIENT FORMS COMPLETION: I understand that an office visit may be necessary if I request the provider complete certain forms for me. There may also be a nominal fee, payable in advance, for the completion of these forms. I understand these requests may take up to 14 days for processing.

PATIENT PORTAL: I understand this practice may have a patient portal to offer me a secure online website for convenient 24-hour access to my personal health information. This is an optional program using a secure username and password. Recent doctor visit notes, medications, contact information and health records can be viewed and printed. The office staff can provide more information regarding the patient portal which may be accessed at https://ebaptisthealthcare.org/PatientPortal.

WIRELESS COMMUNICATION: By providing a wireless or mobile telephone number, I give permission to my provider to use this number for contact. Contact includes receiving calls and messages, including pre-recorded messages and calls via an automatic telephone dialer from the practice and its authorized agents.

NOTICE OF PRIVACY PRACTICES: I understand that Baptist Health Care's Notice of Privacy Practices provides information about how my health information may be used and disclosed. I have been offered and (if requested by me) received a copy of the Notice of Privacy Practices.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ, UNDERSTAND AND CONSENT TO TREATMENT BY BMG AND I AGREE TO ABIDE BY THE ABOVE PATIENT RESPONSIBILITIES.

Patient/Personal Representative Signature	**Date**
Print Patient/Personal Representative Name	**Personal Representative's relationship to patient:**

PATIENT REGISTRATION FORM

PATIENT INFORMATION: THIS SECTION REFERS TO THE PATIENT ONLY

Last Name: ______________________ First Name: _____________________ MI: ______ Social Security #: ___________________

Address: ____ City: _____________________ State: ________ Zip: ________________

Email: ____ Occupation: _________________________________

Date of Birth: ___________ **Sex:** M F **Marital Status:** Married Single Divorced Widowed **Preferred Language:** _________

Race: ☐ American Indian or Alaska native ☐ Asian ☐ Black or African American

☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Unknown/Declined to answer

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown/Declined to answer

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 #: ____

3CNT

Communication with Family Members and Friends Involved In Patient Care

This form documents my request to allow family members and/or friends to be involved in relevant ***verbal discussions*** regarding my health care. By signing this form, I permit Baptist Medical Group ("BMG") staff to discuss information about me with the people listed below. This information may include diagnoses, test results, treatments, and payment information, but shall be limited to only the information that, in the professional judgment of your provider, needs to be shared.

- I understand that signing this form is voluntary and that I am not required to sign this form in order to receive health care.
- I understand that information may be released to family members or others without this form, if allowed by federal and state law.
- I understand that listing a person on this form does not give them the right to receive or copy my written medical records. It does not allow them to consent for health care services on my behalf.
- I understand that my health care provider will discuss only the information that the person involved needs to know about my care or treatment.
- I can update this form at any time by completing a new form and giving it to BMG staff.
- I understand that BMG staff will verify the identity of the people below (if not known to the staff) prior to discussing this information.
- **I understand that this is *not* a Health Insurance Portability and Accountability Act (HIPAA) authorization form that would allow the people below to have access to my written Protected Health Information.**

Name:	Phone #:	Relationship:
Name:	Phone #:	Relationship:
Name:	Phone #:	Relationship:
Name:	Phone #:	Relationship:

Signature: ____

Print Name: ____

Date: ___________________________ Time:___________________________

Relationship to Patient:
□ Self
□ Legal Representative or Guardian (*proof of power of attorney or legal guardianship required*)

1CNT

PRINT: FO/D0H/Whi/1P

NAME ____________________ DOB __________________

Review of Symptoms- MALE

Do you have any of the following symptoms that have brought you in today?

Circle Yes or No

Constitutional

Chills	Y	N
Fatigue	Y	N
Fever	Y	N
Night Sweats	Y	N
Weight Gain	Y	N
Weight Loss	Y	N

Other:______________

HEENT

Ear Drainage	Y	N
Ear Pain	Y	N
Eye Discharge	Y	N
Hearing Loss	Y	N
Nasal Drainage	Y	N
Sinus Pressure	Y	N
Sore Throat	Y	N
Visual Changes	Y	N

Other:______________

Respiratory

Chronic Cough	Y	N
Cough	Y	N
Known Tuberculosis Exposure	Y	N
Shortness of Breath	Y	N
Wheezing	Y	N

Other:______________

Cardiovascular

Chest Pain	Y	N
Pain in Legs	Y	N
Swelling	Y	N
Racing Heart	Y	N

Other:

Gastrointestinal

Abdominal Pain	Y	N
Blood in Stools	Y	N
Change in Stools	Y	N
Diarrhea	Y	N
Heartburn	Y	N
Loss of Appetite	Y	N
Nausea	Y	N
Vomiting	Y	N
Constipation	Y	N

Other:

Genitourinary

Dribbling	Y	N
Pain With Urination	Y	N
Blood in Urine	Y	N
Excessive Urination	Y	N
Slow Stream	Y	N
Need to Urinate Frequently	Y	N
Urinary Incontinence	Y	N
Urinary Retention	Y	N

Other:________________

Reproductive

Erectile Dysfunction	Y	N
Penile Discharge	Y	N
Sexual Dysfunction	Y	N

Other:________________

Metabolic/Endocrine

Brittle Hair	Y	N
Brittle Nails	Y	N
Cold Intolerance	Y	N
Hair Changes	Y	N
Heat Intolerance	Y	N
Hirsutism	Y	N
Increased Thirst	Y	N
Increased Hunger	Y	N

Other:________________

Office Use Only:

HT:______ **WT:** **BP:** **O2** **Temp:** _____ **Pulse:** _________

Neurological

Dizziness	Y	N
Extremity Numbness	Y	N
Extremity Weakness	Y	N
Difficulty Walking	Y	N
Headache	Y	N
Memory Loss	Y	N
Seizures	Y	N
Tremors	Y	N

Other:________________

Psychiatric

Anxiety	Y	N
Depression	Y	N
Insomnia	Y	N

Other:________________

Integumentary

Contact Allergy	Y	N
Hives	Y	N
Itching	Y	N
Mole Changes	Y	N
Rash	Y	N
Skin Lesion	Y	N

Other:________________

Musculoskeletal

Back Pain	Y	N
Joint Pain	Y	N
Joint Swelling	Y	N
Muscle Weakness	Y	N
Neck Pain	Y	N

Other:________________

Hematologic/Lymphatic

Easy Bleeding	Y	N
Easy Bruising	Y	N
Swollen Lymph Nodes/Glands	Y	N

Other:________________

Immunologic

Environmental Allergies	Y	N
Food Allergies	Y	N
Seasonal Allergies	Y	N

Other:________________

Name: ______________________ **DOB** ________

Review of Symptoms- FEMALE

Do you have any of the following symptoms that have brought you in today?

Circle Yes or No

Constitutional

Chills	Y	N
Fatigue	Y	N
Fever	Y	N
Night Sweats	Y	N
Weight Gain	Y	N
Weight Loss	Y	N
Other: ____________		

HEENT

Ear Drainage	Y	N
Ear Pain	Y	N
Eye Discharge	Y	N
Hearing Loss	Y	N
Nasal Drainage	Y	N
Sinus Pressure	Y	N
Sore Throat	Y	N
Visual Changes	Y	N
Other: ____________		

Respiratory

Chronic Cough	Y	N
Cough	Y	N
Known Tuberculosis Exposure	Y	N
Shortness of Breath	Y	N
Wheezing	Y	N
Other: ____________		

Cardiovascular

Chest Pain	Y	N
Pain in Legs	Y	N
Pain in Limbs	Y	N
Swelling	Y	N
Racing Heart	Y	N
Other:		

Gastrointestinal

Abdominal Pain	Y	N
Blood in Stools	Y	N
Change in Stools	Y	N
Diarrhea	Y	N
Heartburn	Y	N
Loss of Appetite	Y	N
Nausea	Y	N
Vomiting	Y	N
Constipation	Y	N
Other: ________		

Genitourinary

Painful Urination	Y	N
Excessive Urination	Y	N
Need To Urinate Frequently	Y	N
Urinary Leakage	Y	N
Urinary Retention	Y	N
Other: ________		

Reproductive

Abnormal Pap Smear	Y	N
Breast Discharge	Y	N
Painful Periods	Y	N
Painful Intercourse	Y	N
Hot Flashes	Y	N
Irregular Period	Y	N
Vaginal Discharge	Y	N
Other: ________		

Metabolic/Endocrine

Brittle Hair	Y	N
Brittle Nails	Y	N
Cold Intolerance	Y	N
Hair Changes	Y	N
Heat Intolerance	Y	N
Excessive Thirst	Y	N
Excessive Appetite	Y	N

Office Use Only:

HT: ______ **WT:** ______ **BP:** ______ **O2:** ______ **Temp:** ______ **Pulse:** ________

Neurological

Dizziness	Y	N
Extremity Numbness	Y	N
Extremity Weakness	Y	N
Difficulty Walking	Y	N
Headache	Y	N
Memory Loss	Y	N
Seizures	Y	N
Tremors	Y	N
Other:______________		

Psychiatric

Anxiety	Y	N
Depression	Y	N
Insomnia	Y	N
Other:______________		

Integumentary

Contact Allergy Y	N	
Hives	Y	N
Itching	Y	N
Mole Changes	Y	N
Rash	Y	N
Skin Lesion	Y	N
Other:______________		

Musculoskeletal

Back Pain	Y	N
Joint Pain	Y	N
Joint Swelling	Y	N
Muscle Weakness	Y	N
Neck Pain	Y	N
Other:______________		

Hematologic/Lymphatic

Easy Bleeding	Y	N
Easy Bruising	Y	N
Swollen Lymph Nodes	Y	N
Other:______________		

Immunologic

Environmental Allergies	Y	N
Food Allergies	Y	N
Seasonal Allergies	Y	N

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
ADD/ADHD				HIV/AIDS			
Allergies				Hyperlipidemia			
Alzheimer's Disease				Hypertension			
Asthma				Immune Deficiency			
Blood Disease				Irritable Bowel Disease/Diverticulitis			
CAD				Neuropathy/Paralysis			
Cancer				Migraines			
CVA – Stroke				Obesity			
Depression/Anxiety				Organ Transplant			
Diabetes				Osteoarthritis/porosis/Rheumatoid			
Eczema				Psychiatric Disorders			
Fibromyalgia				Renal Disease			
Hearing Deficiency				Seizure Disorder			
Heart Disease				Thyroid Disease			
Hepatitis/Liver Disease				Tuberculosis (TB)			

List any medical problems not listed above: ______________________________

Are you experiencing any of the above problems (s) today? ☐ Yes ☐ No If yes, when did the symptoms begin and what symptoms are you experiencing? ______________________________

Please list any surgeries you have had below and, if possible, physician(s) and date(s):

____

____

____

____

____

MEDICATION HISTORY

Do you have any **allergies** to medications (over the counter and/or prescribed) or any other substances? ☐ Yes ☐ No

If yes, please list: ______________________________

Please list current medication(s) or provide a list:

______________ Dosage ________ ______________ Dosage ________

______________ Dosage ________ ______________ Dosage ________

______________ Dosage ________ ______________ Dosage ________

______________ Dosage ________ ______________ Dosage ________

______________ Dosage ________ ______________ Dosage ________

Have you ever had the pneumonia vaccine? ☐ Yes ☐ No Date: __________ Date of last flu vaccine: __________

SOCIAL HISTORY

Smoking/Tobacco? ☐ Yes ☐ No If yes, packs/day: _____ Years: ______ Smokeless Tobacco? ☐ Yes ☐ No
Former Smoker: ☐ Yes ☐ No
Alcohol? ☐ Yes ☐ No Frequency: ______________ Daily Caffine Intake (Coffee, Soda, etc)? ______

Patient Signature: ______________________________ Date: __________

Provider Signature: ______________________________ Date: __________

Preventative Care History Sheet

Patient's Name		Date	
Allergies		D.O.B	

Exam	Date
When was your last flu shot?	
When was your last Pneumonia shot?	
When was your last Tetanus shot?	
When was your last Pap Smear?	
When was your last Mammogram?	
When was your last Dexa Scan?	
When was your last Rectal Exam?	
When was your last Colonoscopy?	
When was your last Prostate/PSA check?	
When was your last Glaucoma Screening?	
When was your last Diabetic-Eye Exam?	
Who is your eye doctor? For diabetic patients only	
Who is your foot doctor? For diabetic patients only	
Do you have an OBGYN doctor? For females only	

Pharmacy Information

Pharmacy Name		Location/Address	
Mail Order Pharmacy Information			

**DO YOU HAVE A LIVING WILL/ADVANCED DIRECTIVE?______ YES ______ NO