

CHIEF COMPLAINT FORM

Date: _____

Patient Name: _____ Preferred Name: _____

Age: _____ DOB: _____ Height: _____ Weight: _____

Occupation: _____

Send Note?

Cardiologist: _____ Town: _____ Y N

Primary Care Physician: _____ Town: _____ Y N

Body part being seen for: _____

Side of Body (circle): Right Left Body

Date Symptoms Began: _____ **Was there an injury?** Yes / No

Workers Comp? Yes / No

If "Yes", how did it happen?

1. **ALLERGIES:** Please list any **allergies** and reactions to medications/substances in the PAST: or (circle) NONE

MEDICATION	REACTION	MEDICATION	REACTION
1)		6)	
2)		7)	
3)		8)	
4)		9)	
5)		10)	

2. **PHARMACY:** Name: _____ Location: _____

3. **MEDICATIONS:** Please list any **medication** you are currently taking:

MEDICATION	DOSE/FREQ	MEDICATION	DOSE/FREQ
1)		9)	
2)		10)	
3)		11)	
4)		12)	
5)		13)	
6)		14)	
7)		15)	
8)		16)	

4. **PAST MEDICAL HISTORY:** Check if you had any of these **medical problems** in the PAST: or (circle) NONE

ILLNESS	Y	ILLNESS	Y	ILLNESS	Y
Anemia		Heart Attack		Peripheral Vascular Disease	
Anxiety		Heart Failure		Psychiatric Illness: _____	
Asthma		Heart Murmur		Pulmonary Embolism	
Bleeding Problems		Hepatitis B		Reflux	
Blood Clot		Hepatitis C		Rheumatoid Arthritis	
Cancer: _____		High Blood Pressure		Sjogren's Disease	
Chest Pain/ Angina		HIV/AIDS		Skin Ulcer/ Breakdown	
COVID-19		Immune Deficiency		Sleep Apnea	
Deep Vein Thrombosis		Kidney Disease		Steroid Use	
Depression		Latex Allergy		Stroke	
Diabetes		Liver Disease		Thyroid Disease	
Gall Bladder Disease		Lupus		Tuberculosis- TB	
Gastric Ulcers		MRSA (resistant staph)		Urinary Infections	
Glaucoma		Neuropathy		Valve Disorders (heart)	
Gout		Osteoarthritis		Wound Healing Problem	
Heart Arrhythmia		Paralysis			

List any **other medical problems** NOT listed above:

5. **PAST SURGICAL HISTORY:** Please list any **operations/surgeries** you had in the PAST: or (circle) NONE

SURGERY/REASON	YEAR	SURGERY/REASON	YEAR
1)		7)	
2)		8)	
3)		9)	
4)		10)	
5)		11)	
6)		12)	

6. **PAST FAMILY HISTORY:** Please list major immediate **family medical problems:** or (circle) NONE

MEDICAL ILLNESS	RELATION	MEDICAL ILLNESS	RELATION
1)		6)	
2)		7)	
3)		8)	
4)		9)	
5)		10)	

7. **SOCIAL HISTORY:** Please circle status use of the following:

Cigarette: Never Former Current Cigarettes per day: _____ Years: _____

Other tobacco: Never Former Current Type: _____ Years: _____

Alcohol: Never Former Current Drinks per day: _____ Type: _____

Illicit Drugs: Never Former Current Type: _____

Patient Registration Form

Last Name:	First Name:	MI:
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Social Security: ____ - ____ - ____	Date of Birth: ____/____/____
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Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Additional gender category or other <input type="checkbox"/> Choose not to disclose. <input type="checkbox"/> Female-to-Male (FTM)/Transgender <input type="checkbox"/> Genderqueer, neither excl male or female <input type="checkbox"/> Male-to-Female (MTF)/Transgender	Marital Status: <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Legally Sep <input type="checkbox"/> Widowed <input type="checkbox"/> Life Partner <input type="checkbox"/> Unknown <input type="checkbox"/> Married
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Address:	City:	State:	Zip:
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Email:

Primary Phone: (____) ____ - ____ <input type="checkbox"/> Home Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Work Phone	Secondary Phone: (____) ____ - ____ <input type="checkbox"/> Home Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Work Phone
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Preferred Language: _____

Race: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Unknown/Decline to Answer	Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown/Decline to Answer	U.S. Citizenship Status: <input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Lawfully present in the U.S. <input type="checkbox"/> Not lawfully present in the U.S. <input type="checkbox"/> Decline to Answer
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Responsible Party: This section refers to the person/party who should receive the bill

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

Last Name:	First Name:	MI:
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Social Security: ____ - ____ - ____	Date of Birth: ____/____/____	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
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Address:	City:	State:	Zip:
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Primary Phone: (____) ____ - ____	Secondary Phone: (____) ____ - ____
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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 Number	Relationship
Name	Phone Number	Relationship
Name	Phone Number	Relationship
Name	Phone Number	Relationship

Signature	_____	
Print Name	_____	
Date	___ / ___ / ____	Time ___ : ____

Relationship to Patient

Self

Legal Representative or Guardian (proof of power of attorney or legal guardianship required)

