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 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)

PRINT: FO/D0H/Whi/1P

Welcome to Baptist Medical Group - Urology.

We would like to take this opportunity to welcome you to our practice and we look forward to providing the highest quality urologic care. To expedite your registration and check-in process, please take a few moments to complete the enclosed registration and medical history forms and bring them with you to your appointment.

Please bring the following to your appointment:

- Completed forms
- Insurance cards
- Driver's license or picture ID
- Insurance co pay
- List of medications and allergies
- CD or x-ray reports, if performed, relating to your problem

If your insurance requires a referral or pre-authorization when seeing a specialist, please contact your primary care physician and confirm this has been completed.

We appreciate you taking the time to help us streamline your visit and serve you as efficiently as possible. If you have any questions or need any assistance, please call our office, we will be happy to help you in any way we can. We look forward to meeting you!

Healthy Regards,

Baptist Medical Group - Urology

Patient Name: ___________________________________ DOB: ________________ Date: ________________

PATIENT REVIEW OF SYSTEMS

These questions pertain to the **patient only**.
Please check yes if you experience the problem currently or within the last 3 months.

Constitutional	**No**	**Yes**	**Metabolic/Endocrine**	**No**	**Yes**
Chills/rigors			Cold Intolerance		
Fatigue			Heat Intolerance		
Fever			Weight Gain		
Night Sweats					
Weight Loss			**Neuro/Psychiatric**	**No**	**Yes**
			Dizziness		
HEENT	**No**	**Yes**	Difficulty Speaking		
Headache			Weakness		
Infections			Trouble Walking		
Visual Loss			Incontinence (Loss of Bowel or Bladder)		
Facial Pain			Incoordination		
Difficulty Swallowing			Light-headedness		
			Loss of Consciousness		
Respiratory	**No**	**Yes**	Memory Impairment		
Cough			Fainting Spells		
Difficulty Breathing			Numbness, Tingling		
Phlegm			Seizures		
			Speech Changes		
Cardiovascular	**No**	**Yes**	Tremors		
Chest Pain			Vertigo		
Swelling			Visual Changes		
Irregular Heartbeat/Palpitations					
			Dermatologic	**No**	**Yes**
Vascular	**No**	**Yes**	Contact Allergy		
Leg Cramps with Activity			Frequent Skin Infections		
Cool Extremity			Rash		
Blue Coloring to Extremity					
Skin Redness			**Musculoskeletal**	**No**	**Yes**
Raynaud's			Back Pain		
			Bone/Joint Symptoms		
Gastrointestinal	**No**	**Yes**	Muscle Pain		
Abdominal Pain			Muscle Weakness		
Change in Appetite			Neck Stiffness		
Constipation					
Diarrhea			**Hematologic**	**No**	**Yes**
Nausea			Easy Bleeding		
Vomiting			Easy Bruising		
			Blood Clots (leg, lung)		
Genitourinary	**No**	**Yes**			
Painful/Difficult Urination					
Frequent Urination					
Urinary Incontinence					

PATIENT & FAMILY HISTORY

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

	Patient	**Family**		**Patient**	**Family**
Anemia			Liver Disease		
Asthma/COPD			Neuropathy		
Bleeding Disorder			Organ Transplant (**specify**)________________		
Blood clots (Leg/Lung)			Osteoarthritis or Rheumatoid Arthritis		
Cancer Type:			Peripheral Vascular Disease		
Depression			Pneumonia		
Diabetes			Psychiatric Illness (**specify**)__________________		
Fibromyalgia			Reflux/GERD		
Glaucoma/Visual Loss			Seizure Disorder		
Hearing Loss			Steroid Use		
Heart (Circle): Heart Attack, Congestive Heart Failure, Irregular Heartbeat, Heart Murmur			Skin Ulcer/Breakdown/Wound Healing Problems		
Hepatitis B/C			Stomach Ulcers/Heartburn		
High Blood Pressure			Stroke		
HIV/AIDS			Thyroid Disease		
Immune Deficiency/STDs			Tuberculosis (TB)		
Kidney Disease/Stones			Urinary Problems		
List any medical problems not listed above: ____ ____					

Pneumonia Vaccine?	Yes___	No___	Date:	Flu Vaccine?	Yes___	No___	Date:

Do you have **ALLERGIES? (medication, latex, environmental, or food)   Yes ____   No ____
If yes, please list: ____

List all medications you are taking, including over-the-counter and herbal supplements, or provide a list:			
Medication	**Dosage** (mg)	**How many times/day?**	**Prescribing Provider**
1.			
2.			
3.			
4.			
5.			
6.			
7.			

PAST SURGICAL HISTORY – List surgeries below, or provide a list:		
Surgery	**Date**	**Surgeon**
1.		
2.		
3.		
4.		

Do you currently smoke tobacco? Yes___ No___ Former smoker? Yes___ No___ If yes, packs/day:____ Years: ____
Smokeless tobacco? Yes___ No___ Former_____
Alcohol? Yes___ No___ How often? _______________ Do you drink caffeine (coffee, soda, tea) ? Yes___ No___

Patient Signature:	Date: