Patient Registration Form

Last Name:	First Name:	MI:

Social Security: _____ - ____ - _____	Date of Birth: _____/_____/_____

Gender: ☐ Male ☐ Female ☐ Additional gender category or other ☐ Choose not to disclose. ☐ Female-to-Male (FTM)/Transgender ☐ Genderqueer, neither excl male or female ☐ Male-to-Female (MTF)/Transgender	Marital Status: ☐ Divorced ☐ Single ☐ Legally Sep ☐ Widowed ☐ Life Partner ☐ Unknown ☐ Married

Address:	City:	State:	Zip:

Email:

Primary Phone: (_____) _____-_____ ☐ Home Phone ☐ Cell Phone ☐ Work Phone	Secondary Phone: (_____) _____-_____ ☐ Home Phone ☐ Cell Phone ☐ Work Phone

Preferred Language: _____

Race: ☐ American Indian or Alaska Native ☐ Native Hawaiian or other Pacific Islander ☐ Asian ☐ Black or African American ☐ White ☐ Unknown/Decline to Answer	Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown/Decline to Answer	U.S. Citizenship Status: ☐ U.S. Citizen ☐ Lawfully present in the U.S. ☐ Not lawfully present in the U.S. ☐ Decline to Answer

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:

Social Security: _____ - ____ - _____	Date of Birth: _____/_____/_____	Gender: ☐ M ☐ F

Address:	City:	State:	Zip:

Primary Phone: (_____) _____-_____	Secondary Phone: (_____) _____- _____

New PT Paperwork

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)

Patient Name: _____ DOB: _____
Today's Chief Complaint: _____ Referring Doctor: _____

PATIENT MEDICAL HISTORY

Please **circle** any medical problem(s) you have had in the past or may currently have.

Allergies	Headache, migraine
Anemia	Hearing disorders
Anxiety	Hypertension
Birth trauma	Hyperthyroidism
Bleeding disorder	Hypothyroidism
Cancer	Micrognathia
Chronic infection	Multinodular goiter
Cleft lip	Obesity
Cleft palate	Otitis media
COPD	Otosclerosis
Coronary artery disease	Seizure disorder
Depression	Sleep apnea
Diabetes	Stroke
Elevated lipids	Tinnitus
Emphysema	Vertigo
ENT syndromes	Other:
GERD	Other:

PATIENT REVIEW OF SYSTEMS

Please **circle** any symptoms below you may currently have.

Chills	Nose discharge	Difficulty Breathing	Dizziness
Fever	Nose bleeds	Shortness of Breath	Headache
Malaise/Fatigue	Nose obstruction	Sputum production	Numbness
Weight loss	Decreased sense of smell	Chest Pain	Weakness
Skin lesions	Running nose	Palpitations	Change in speech
Skin rash	Dysphagia	Fainting	Difficulty speaking
Skin color change	Hoarseness	Irregular heart beat	Tingling
Eye itching	Mouth lesions	Abdominal pain	Loss of balance
Photophobia	Mouth rash	Constipation	Seizures
Vision changes	Throat pain	Diarrhea	Anxiety
Visual disturbances	Coated tongue	Nausea/vomiting	Depression
Eye dryness	Dental problems	Difficulty swallowing	Insomnia
Ear discharge	Sore throat	Heartburn	Enlarged lymph node
Hearing disturbance	Voice changes	Indigestion	Night sweats
Hearing loss	Mouth dryness	Dysuria	Abnormal bleeding
Ear pain	Cough	Urinary frequency	Change in weight
Tinnitus	Dyspnea	Confusion/memory loss	Cold/heat tolerance
Congestion	Wheezing	Other:	

PATIENT SOCIAL HISTORY

Please **circle** below and provide frequency of use:

Smoking/tobacco – Frequency: _____	Live with someone who smokes	Former smoker
Smokeless tobacco – Frequency: _____	Alcohol – Frequency: _____	Caffeine – Frequency: _____

PATIENT SURGICAL HISTORY

Please **circle** any past surgical history you may have and provide the date beside it.

Adenoidectomy	Angioplasty	Appendectomy	Back surgery	Blood transfusion
CABG	Cholecystectomy	Hernia repair	Hip replacement	Knee replacement
Sinus surgery	Thyroidectomy	Tonsillectomy	**Please write any additional in the space below:**	

MEDICATION HISTORY

Allergy	Severity (Minor, Moderate, Major)	Reaction

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

_____

FAMILY MEDICAL HISTORY

Please **circle** any relevant family medical history. If circled, please write in onset age and relationship to patient.

	Onset age/relationship		Onset age/relationship		Onset age/relationship
Allergies		Deafness		Obesity	
Asthma		Depression		Otosclerosis	
Autoimmune disease		Developmental delay		Renal disease	
Blood disorder		Diabetes		Seizure disorder	
Cancer		Elevated lipids		Sickle cell	
Cardiovascular disease		Genetic disease		Sleep apnea	
Chronic otitis media		GERD		Stroke	
Cleft lip		Hearing disorder		Thyroid Disorder	
Cleft palate		Hypertension		Other:	
Coronary artery disease		Migraines		Other:	

Patient Signature: _____ **Date:** _____