Orthopedic Trauma & Fracture Care

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Today's Date: ___________________________

Patient Name: ____________________________________ **Date of Birth:** __________________

Age: _____ **Male** ____ **Female** ____ **Height** ______ **Weight** ________

Chief Complaint: Why are you here today?

Describe how the accident or injury happened:

Date of Injury: ___________________________

Was injury due to auto accident? **Yes**_____ **No**_____ **City/State:** ___________________________

Was the injury related to your job? **Yes**_____ **No** ____

What is your occupation? ____

Employer: ____

Patient Name: ____________________________ Date of Birth: _____________

Medical History:

Primary Care Physician: ____ Phone:_________________

Do you have an Advanced Directive or Power of Attorney that you would like for us to have one file?

Yes _____ No ______ If Yes, please provide documents to front desk.

Medications – Please list all medications you are taking now. Please include over the counter medications:

Medication	***Dosage***	***How Often***

Medication/Food Allergies or Intolerances:

Medication/Food	***Reaction***

Are you allergic to LATEX? Yes _____ No _____

Review of Systems:

Have you had any of the following symptoms in the past six (6) months?

GENERAL

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

GASTROINTESTINAL

Abdominal Pain	Y	N
Constipation	Y	N
Change in Stools	Y	N
Bloody/Black Stools	Y	N
Diarrhea	Y	N
Nausea	Y	N
Vomiting	Y	N

CARDIOVASCULAR

Irregular Heartbeat	Y	N
Pain in Chest	Y	N
Swelling	Y	N
Fainting	Y	N

Patient Name: ____________________________ Date of Birth: _____________

EYES

Blurred vision	Y	N
Double vision	Y	N
Vision Loss	Y	N
Pain	Y	N

GENITOURINARY

Frequent urination	Y	N
Blood in urine	Y	N
Incontinence	Y	N

RESPIRATORY

Shortness of Breath	Y	N
Chest Pain	Y	N
Wheezing	Y	N
Cough	Y	N

EARS, NOSE, THROAT

Hearing loss	Y	N
Ringing in ears	Y	N
Sinusitis	Y	N
Hoarseness	Y	N
Lump in throat	Y	N
Diff swallowing	Y	N

MUSCULOSKELETAL

Joint pain	Y	N
Back pain	Y	N
Muscle weakness	Y	N
Bruising	Y	N
Bleeding	Y	N

NEUROLOGIC

Seizures	Y	N
Numbness	Y	N
Headaches	Y	N
Dizziness	Y	N

SKIN

Rashes	Y	N
Lesions	Y	N

Do you have any of the following problems?

_____Arthritis
_____Lung Problems
_____Bleeding
_____Diabetes
_____HIV/AIDS
_____Heart Problems/Attacks
_____Liver
_____Cancer
_____Hypertension
_____High Cholesterol
_____Hepatitis A,B,C
_____Anemia
_____OTHER

Please explain any above problems: ____
____
____

Have you been hospitalized in past 5 years? _____Yes _____No

If Yes, please explain:

____
____
____

Have you had any kind of reaction to anesthesia during surgery? _____Yes _____No

If Yes, please explain:

____
____

Patient Name: ____________________________ Date of Birth: _____________

FEMALE PATIENTS ONLY:

Are you pregnant? Is there a chance you could be pregnant? YES ______ NO _____

Date of LMP: ________________________________

Family History:

Has anyone in your immediate family (parents, grandparents, siblings, children) ever had?

	Who?		Who?
___Anesthesia problems	________________	___High Cholesterol	________________
___Arthritis	________________	___Liver Problems	________________
___Asthma, Hay Fever, Allergy	________________	___Lung Problems	________________
___Bone Disease	________________	___Mental Illness	________________
___Cancer	________________	___Seizures/Epilepsy	________________
___Diabetes	________________	___Sickle Cell Anemia	________________
___Glaucoma	________________	___Stroke	________________
___Heart Attack/Problems	________________	___Thyroid Disorders	________________
___High Blood Pressure	________________	___Tuberculosis	________________
___Kidney Stones	________________	___Ulcers	________________
___Bleeding Problems	________________	___Other	________________

Explain any other problems: ____

Social History:

Marital Status: Single Married Separated Divorced Widow

Do you have children? YES NO How many? ____

Do you have brothers or sisters? #_____ Brothers #_____ Sisters

Living situation: Who do you live with? ____

Type of sports activities do you participate in?____

Do you smoke, vape, any nicotine? YES NO What/How often___________________________________

Do you drink alcohol? YES NO How often? ____

Do you use recreational drugs? YES NO What/How often? __________________________________

Are you a victim of domestic violence or not in a safe environment? YES NO

PATIENT/LEGAL GUARDIAN DATE

PHYSICIAN DATE

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 #: ____

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)