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)

Name: _____ *DOB:* _____ *Pharmacy:*_____ *Date:* _____

PCP: _____ *Health Insurance:* _____

Previous Providers: _____

New Patients (only) Reason for Visit: _____

Please answer each question, even if you do not think it applies to you at this time. Try to complete as much as you can yourself, but if you need help, please direct your questions to your nurse. There is no right or wrong answers. Please answer exactly how you think or feel right now.

Over the last week were you able to	Without ANY difficulty	With SOME difficulty	With MUCH difficulty	UNABLE to do
A. Dress yourself, including tying shoelaces and doing buttons?	____0	____1	____2	____3
B. Get in and out of bed?	____0	____1	____2	____3
C. Lift a cup or glass to your mouth?	____0	____1	____2	____3
D. Walk outdoors on flat ground?	____0	____1	____2	____3
E. Wash and dry your entire body?	____0	____1	____2	____3
F. Bend down to pick up clothing from the floor?	____0	____1	____2	____3
G. Turn regular faucets on and off?	____0	____1	____2	____3
H. Get in and out of a car, bus, train or airplane?	____0	____1	____2	____3
I. Walk two miles or three kilometers, if you wish?	____0	____1	____2	____3
J. Participate in recreational activities and sports as you would like, if you wish?	____0	____1	____2	____3
K. Deal with feelings of depression or feeling blue?	____0	____1.1	____2.2	____3.3

Please check the <u>ONE</u> best answer for your abilities at this time:

1. How much pain have you had because of your condition OVER THE PAST WEEK? Please indicate below how severe your pain has been?

<u>No pain</u> **<u>Pain as bad as it could be</u>**

0	0.5	1.0	1.5	2.0	2.5	3.0	3.5	4.0	4.5	5.0	5.5	6.0	6.5	7.0	7.5	8.0	8.5	9.0	9.5	10

2. **Considering all the ways in which illness and health conditions may affect you at this time, please indicate how well you are doing?**

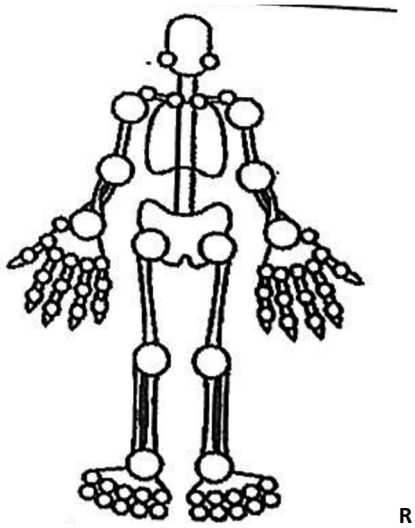
<u>Very well</u> **<u>Very Poorly</u>**

0	0.5	1.0	1.5	2.0	2.5	3.0	3.5	4.0	4.5	5.0	5.5	6.0	6.5	7.0	7.5	8.0	8.5	9.0	9.5	10

Form continues on next page: ⇨

Please indicate on the diagram which joints are or have been painful and/or swollen within the past week.

<u>OFFICE USE ONLY:</u> **H**:_____ **W**:_____ **BP**:_____/_____ **P**:_____ **O2**:_____



L **R**

What is your current pain level?

No pain **(0-10)** *Extreme pain* _____

Medication Allergies and Reactions:

Allergy	**Reaction**
Example: Penicillin	*Hives*

Medications:

	Name of Medication	**Dose**	**Directions**
	Example :Tylenol	*325mg*	*One tablet every six hours as needed*
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10			

Name:_____ DOB:_____

Past Medical History

OFFICE USE ONLY: **H**:_____ **W**:_____ **BP**:_____/_____ **P**:_____ **O2**:_____

Do you now or have you ever had- please check (√)

	Cancer:		*Jaundice*		*Psoriasis*
	Goiter		*Pneumonia*		*Lupus*
	Cataracts		*HIV/AIDS*		*Ankylosing Spondylitis*
	Headaches		*Glaucoma*		*Osteoporosis*
	Kidney Disease		*Asthma*		*Gout*
	Anemia		*Stroke*		*Colitis*
	COPD		*Seizures*		*Irritable Bowel*
	Heart Disease		*Osteoarthritis*		*Hepatitis:*
	Leukemia		*Rheumatoid Arthritis*		*Tuberculosis*
	Stomach Ulcers		*JIA*		*Multiple Sclerosis*

Family Medical History

Do you know of any blood relatives that has or had- please check (√)

	Cancer:		*Rheumatoid Arthritis*
	Heart Disease		*Lupus*
	Stroke		*Ankylosing Spondylitis*
	Psoriasis		*Multiple Sclerosis*

(Women Only) last menstrual period date: _____

Surgeries/Dates: *existing patients list last 6 mos.* ***New Patients*** *list all surgeries.* ☐ ***NO CHANGE***

Any Tobacco use: Current Former Never

Tobacco type: _____How much daily: _____Year(s) quit/used_____ ☐ ***NO CHANGE***

Alcohol use: Current Former Never *Year(s) quit/used_____*

Alcohol type: Wine Beer Liquor How much/Often_____ ☐ ***NO CHANGE***

Caffeine use: Current Former Never *How much/Often_____* ☐ ***CHANGE***

Caffeine type: Coffee Soda Tea Energy drinks Chocolate Tablets

OFFICE USE ONLY: **H**:_____ **W**:_____ **BP**:_____/_____ **P**:_____ **O2**:_____