

Patient Registration Form

Last Name:		First Name:		MI:	
Social Security: ____ - ____ - ____		Date of Birth: ____/____/____			
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		
Address:		City:		State:	Zip:
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		
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	
Responsible Party: This section refers to the person/party who should receive the bill					
Relationship to Patient: <input type="checkbox"/> Self (skip this section) <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Other					
Last Name:		First Name:		MI:	
Social Security: ____ - ____ - ____		Date of Birth: ____/____/____		Gender: <input type="checkbox"/> M <input type="checkbox"/> F	
Address:		City:		State:	Zip:
Primary Phone: (____) ____ - ____		Secondary Phone: (____) ____ - ____			



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 HISTORY FORM

Name: _____ Date of Birth: _____

Social Security #: _____ Referring Physician: _____

Reason for Referral: _____

PHYSICIANS List all doctors providing care

Doctor's Name	Type of Doctor <i>Primary Care, Surgeon, Urologist, etc.</i>	Reason for seeing this doctor

ALLERGIES Do you have allergies to drugs, food, seafood, latex, dye? ☐ Yes ☐ No

Allergy to:	Reaction- rash, shortness of breath, hives, itching, etc.

CURRENT MEDICATIONS

List all vitamins, prescription medications, and over-the-counter medications

★ Bring ALL MEDICATION in their original containers to every appointment.

Medication name	Dosage	How often do you take?	Prescribing Physician

PAST MEDICAL & SURGICAL HISTORY

<p><u>EENT</u></p> <p><input type="checkbox"/> Cataracts</p> <p><input type="checkbox"/> Diabetic Retinopathy</p> <p><input type="checkbox"/> Glaucoma</p> <p><input type="checkbox"/> Macular Degeneration</p> <p><input type="checkbox"/> Retinal Detachment</p> <p><input type="checkbox"/> Sinusitis</p> <p><input type="checkbox"/> Tinnitus</p> <p><input type="checkbox"/> Tonsillitis</p> <p><input type="checkbox"/> Other: _____</p> <p><u>Respiratory</u></p> <p><input type="checkbox"/> ARDS (Adult Resp. Distress Syndrome)</p> <p><input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> COPD</p> <p><input type="checkbox"/> Pneumonia</p> <p><input type="checkbox"/> Pulmonary Embolus (clot)</p> <p><input type="checkbox"/> Pulmonary Hypertension</p> <p><input type="checkbox"/> Sleep Apnea, CPAP</p> <p><input type="checkbox"/> Tuberculosis</p> <p><input type="checkbox"/> Other: _____</p> <p><u>Cardiac</u></p> <p><input type="checkbox"/> Arrhythmias</p> <p><input type="checkbox"/> Cardiomyopathy</p> <p><input type="checkbox"/> Congestive Heart Failure</p> <p><input type="checkbox"/> Coronary Artery Disease</p> <p><input type="checkbox"/> Hypertension</p> <p><input type="checkbox"/> Myocardial Infarction (heart attack)</p> <p><input type="checkbox"/> Sudden Death</p> <p><input type="checkbox"/> Valvular Heart Disease</p> <p><input type="checkbox"/> Other: _____</p> <p><u>Vascular</u></p> <p><input type="checkbox"/> Aortic Aneurysm</p> <p><input type="checkbox"/> Carotid Disease</p> <p><input type="checkbox"/> Claudication</p> <p><input type="checkbox"/> DVT</p> <p><input type="checkbox"/> Peripheral Vascular Disease</p> <p><input type="checkbox"/> Phlebitis</p> <p><input type="checkbox"/> Raynaud's</p> <p><input type="checkbox"/> Varicose Veins</p> <p><input type="checkbox"/> Other: _____</p>	<p><u>Gastrointestinal</u></p> <p><input type="checkbox"/> Cirrhosis</p> <p><input type="checkbox"/> GERD</p> <p><input type="checkbox"/> Hepatitis</p> <p><input type="checkbox"/> Hiatal Hernia</p> <p><input type="checkbox"/> Pancreatitis</p> <p><input type="checkbox"/> Peptic Ulcer Disease</p> <p><input type="checkbox"/> Ulcerative Colitis</p> <p><input type="checkbox"/> Other: _____</p> <p><u>Renal/GU</u></p> <p><input type="checkbox"/> Bladder Cancer</p> <p><input type="checkbox"/> BPH (enlarged prostate)</p> <p><input type="checkbox"/> End Stage Renal Disease</p> <p><input type="checkbox"/> Kidney Stones</p> <p><input type="checkbox"/> Prostate Cancer</p> <p><input type="checkbox"/> Prostatitis</p> <p><input type="checkbox"/> Renal Artery Stenosis</p> <p><input type="checkbox"/> Renal Failure</p> <p><input type="checkbox"/> Renal Insufficiency</p> <p><input type="checkbox"/> Other: _____</p> <p><u>GYN</u></p> <p><input type="checkbox"/> Benign Breast Lump</p> <p><input type="checkbox"/> Breast Cancer</p> <p><input type="checkbox"/> Cervical Cancer</p> <p><input type="checkbox"/> Ovarian Cancer</p> <p><input type="checkbox"/> Other: _____</p> <p><u>Musculoskeletal</u></p> <p><input type="checkbox"/> Back Pain</p> <p><input type="checkbox"/> Gout</p> <p><input type="checkbox"/> Lupus</p> <p><input type="checkbox"/> MVA Trauma</p> <p><input type="checkbox"/> Rheumatoid Arthritis</p> <p><input type="checkbox"/> Other: _____</p> <p><u>Skin</u></p> <p><input type="checkbox"/> Cellulitis</p> <p><input type="checkbox"/> Hives</p> <p><input type="checkbox"/> Psoriasis</p> <p><input type="checkbox"/> Scleroderma</p> <p><input type="checkbox"/> Skin Cancer</p> <p><input type="checkbox"/> Other: _____</p>	<p><u>Neurologic</u></p> <p><input type="checkbox"/> Alzheimer's Disease</p> <p><input type="checkbox"/> CVA</p> <p><input type="checkbox"/> Dementia</p> <p><input type="checkbox"/> Diabetic Neuropathy</p> <p><input type="checkbox"/> Fibromyalgia</p> <p><input type="checkbox"/> Migraines</p> <p><input type="checkbox"/> Multiple Sclerosis</p> <p><input type="checkbox"/> Parkinson's Disease</p> <p><input type="checkbox"/> Seizure Disorder</p> <p><input type="checkbox"/> Syncope</p> <p><input type="checkbox"/> TIA</p> <p><input type="checkbox"/> Other: _____</p> <p><u>Psychiatric</u></p> <p><input type="checkbox"/> Alcoholism</p> <p><input type="checkbox"/> Anorexia</p> <p><input type="checkbox"/> Bipolar Disorder</p> <p><input type="checkbox"/> Chronic Anxiety</p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Panic Disorder</p> <p><input type="checkbox"/> Post-Traumatic Stress Disorder</p> <p><input type="checkbox"/> Other: _____</p> <p><u>Hematologic</u></p> <p><input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> Other: _____</p> <p><u>Endocrine</u></p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Thyroid</p> <p><input type="checkbox"/> Other: _____</p> <p><u>Infectious Disease</u></p> <p><input type="checkbox"/> Endocarditis</p> <p><input type="checkbox"/> HIV</p> <p><input type="checkbox"/> Other: _____</p> <p><u>Recent Hospitalizations</u></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>List Hospital/Date/Reason for hospitalization: _____</p> <p>_____</p> <p>_____</p> <p>_____</p>																																																					
<p><u>Cardiac Surgeries & Procedures</u></p> <table style="width: 100%;"> <tr><td><input type="checkbox"/> Cardiac Cath</td><td>Year _____</td></tr> <tr><td><input type="checkbox"/> Cardioversion</td><td>Year _____</td></tr> <tr><td><input type="checkbox"/> Coronary Angioplasty/Stent</td><td>Year _____</td></tr> <tr><td><input type="checkbox"/> Coronary Artery Bypass</td><td>Year _____</td></tr> <tr><td><input type="checkbox"/> EP Study</td><td>Year _____</td></tr> <tr><td><input type="checkbox"/> ICD Placement</td><td>Year _____</td></tr> <tr><td><input type="checkbox"/> Pacemaker Implant</td><td>Year _____</td></tr> <tr><td><input type="checkbox"/> RF Ablation</td><td>Year _____</td></tr> <tr><td><input type="checkbox"/> Heart Valve Repair/Replaced</td><td>Year _____</td></tr> <tr><td><input type="checkbox"/> Other: (List Below)</td><td>Year _____</td></tr> <tr><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td></tr> </table>	<input type="checkbox"/> Cardiac Cath	Year _____	<input type="checkbox"/> Cardioversion	Year _____	<input type="checkbox"/> Coronary Angioplasty/Stent	Year _____	<input type="checkbox"/> Coronary Artery Bypass	Year _____	<input type="checkbox"/> EP Study	Year _____	<input type="checkbox"/> ICD Placement	Year _____	<input type="checkbox"/> Pacemaker Implant	Year _____	<input type="checkbox"/> RF Ablation	Year _____	<input type="checkbox"/> Heart Valve Repair/Replaced	Year _____	<input type="checkbox"/> Other: (List Below)	Year _____	_____	_____	_____	_____	_____	_____	<p><u>Other Surgeries & Procedures</u></p> <table style="width: 100%;"> <tr><td><input type="checkbox"/> Aneurysm Repair</td><td>Year _____</td></tr> <tr><td><input type="checkbox"/> Appendectomy</td><td>Year _____</td></tr> <tr><td><input type="checkbox"/> Back surgery</td><td>Year _____</td></tr> <tr><td><input type="checkbox"/> Carotid Surgery</td><td>Year _____</td></tr> <tr><td><input type="checkbox"/> Cholecystectomy (Gallbladder removed)</td><td>Year _____</td></tr> <tr><td><input type="checkbox"/> Gastric Bypass</td><td>Year _____</td></tr> <tr><td><input type="checkbox"/> Hysterectomy</td><td>Year _____</td></tr> <tr><td><input type="checkbox"/> Kidney Stone Treatment</td><td>Year _____</td></tr> <tr><td><input type="checkbox"/> Knee Surgery</td><td>Year _____</td></tr> <tr><td><input type="checkbox"/> Mastectomy</td><td>Year _____</td></tr> <tr><td><input type="checkbox"/> Nephrectomy (Kidney removed)</td><td>Year _____</td></tr> <tr><td><input type="checkbox"/> Tonsillectomy</td><td>Year _____</td></tr> <tr><td><input type="checkbox"/> Thyroidectomy</td><td>Year _____</td></tr> <tr><td><input type="checkbox"/> Other: _____</td><td>Year _____</td></tr> </table>	<input type="checkbox"/> Aneurysm Repair	Year _____	<input type="checkbox"/> Appendectomy	Year _____	<input type="checkbox"/> Back surgery	Year _____	<input type="checkbox"/> Carotid Surgery	Year _____	<input type="checkbox"/> Cholecystectomy (Gallbladder removed)	Year _____	<input type="checkbox"/> Gastric Bypass	Year _____	<input type="checkbox"/> Hysterectomy	Year _____	<input type="checkbox"/> Kidney Stone Treatment	Year _____	<input type="checkbox"/> Knee Surgery	Year _____	<input type="checkbox"/> Mastectomy	Year _____	<input type="checkbox"/> Nephrectomy (Kidney removed)	Year _____	<input type="checkbox"/> Tonsillectomy	Year _____	<input type="checkbox"/> Thyroidectomy	Year _____	<input type="checkbox"/> Other: _____	Year _____
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SOCIAL & FAMILY HISTORY

<u>Alcohol Use</u> Do you consume alcohol <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Former Frequency: _____ Year quit: _____ <u>Smoking/Tobacco Use</u> Do you smoke/use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Former Type: <input type="checkbox"/> Cigarettes <input type="checkbox"/> Pipe <input type="checkbox"/> Cigar <input type="checkbox"/> Smokeless Number of years smoked: _____ Packs per day: _____ Years quit: _____ Passive Smoke Exposure: <input type="checkbox"/> Yes <input type="checkbox"/> No	<u>Diet</u> Are you on a special diet? <input type="checkbox"/> Yes <input type="checkbox"/> No What type of diet? _____ Do you drink caffeine? <input type="checkbox"/> Yes <input type="checkbox"/> No How much a day? _____ Do you eat much chocolate a day? <input type="checkbox"/> Yes <input type="checkbox"/> No <u>Exercise</u> Do you exercise regularly? (minimum of 30 minutes/3 times a week) <input type="checkbox"/> Yes <input type="checkbox"/> No If YES describe: _____ <u>Religion:</u> Agree to Transfusion <input type="checkbox"/> Yes <input type="checkbox"/> No	<u>Drug Use/Abuse</u> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Former Substance type: _____ Years quit: _____ <u>Marital Status:</u> _____ <u>Occupation</u> List: _____ <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <u>Residence</u> Live with: _____ <input type="checkbox"/> Nursing home <input type="checkbox"/> Assisted Living <u>Advanced Directives</u> <input type="checkbox"/> None <input type="checkbox"/> DNR <input type="checkbox"/> HC Proxy <input type="checkbox"/> Living Will Date: _____
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Is there a Family History of: (List All Family Members):

Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Family Member	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Family Member	_____
Coronary Bypass Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Family Member	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Family Member	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Family Member	_____
Coronary Artery Disease	<input type="checkbox"/>	<input type="checkbox"/>	Family Member	_____
Sudden Death	<input type="checkbox"/>	<input type="checkbox"/>	Family Member	_____

REVIEW OF SYSTEMS Check if you are experiencing any of the symptoms listed below.

<u>General</u> <input type="checkbox"/> Decreased appetite <input type="checkbox"/> Fever <input type="checkbox"/> Chills <input type="checkbox"/> Weight change (Loss or Gain) <input type="checkbox"/> Night sweats <input type="checkbox"/> Fatigue <u>HEENT</u> <input type="checkbox"/> Headache <input type="checkbox"/> Glaucoma <input type="checkbox"/> Cataracts <input type="checkbox"/> Double vision <input type="checkbox"/> Blurred vision <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Hearing loss <input type="checkbox"/> Hoarseness <input type="checkbox"/> Nosebleeds <u>Respiratory</u> <input type="checkbox"/> Persistent cough <input type="checkbox"/> Shortness of breath with rest <input type="checkbox"/> Shortness of breath with activity <input type="checkbox"/> Snoring <input type="checkbox"/> Coughing up blood <input type="checkbox"/> Wheezing <input type="checkbox"/> # of pillows used to sleep on _____	<u>Cardiovascular</u> <input type="checkbox"/> Chest pain, pressure or tightness <input type="checkbox"/> Passing out <input type="checkbox"/> Heart palpitations <input type="checkbox"/> History of blood clots or phlebitis <input type="checkbox"/> Irregular heart beats <input type="checkbox"/> Non-healing sores on legs or feet <input type="checkbox"/> Pain in legs/hips with walking <input type="checkbox"/> Shortness of breath lying flat <input type="checkbox"/> Swelling of feet or ankles <input type="checkbox"/> Waking up panicky & short of breath <input type="checkbox"/> Dizziness <u>Gastrointestinal</u> <input type="checkbox"/> Nausea and vomiting <input type="checkbox"/> Nausea without vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Heartburn/Indigestion <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Black tarry stools <input type="checkbox"/> Difficulty swallowing solids/liquids <u>Endocrine</u> <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Increased urination <input type="checkbox"/> Hair loss <u>Hematological</u> <input type="checkbox"/> Bleed easily <input type="checkbox"/> Bruise easily	<u>Neurological</u> <input type="checkbox"/> Headaches <input type="checkbox"/> Numbness/tingling on one side <input type="checkbox"/> Weakness on one side <input type="checkbox"/> Difficulty speaking <input type="checkbox"/> Loss of memory <u>Musculoskeletal</u> <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Joint stiffness <input type="checkbox"/> Arthritis <input type="checkbox"/> Gout <input type="checkbox"/> Muscle cramps <u>Genitourinary</u> <input type="checkbox"/> Blood in urine <input type="checkbox"/> Pain with urination <input type="checkbox"/> Frequency of urination <input type="checkbox"/> Urgency of urination <input type="checkbox"/> Incontinence <u>Males:</u> <input type="checkbox"/> Difficulty starting stream <input type="checkbox"/> Wake up at night to urinate <input type="checkbox"/> History of urinary retention <input type="checkbox"/> Prostate problems <input type="checkbox"/> Erectile dysfunction <u>Females:</u> Date of last menstrual period: _____ <input type="checkbox"/> Currently on Birth Control Menopause: <input type="checkbox"/> Yes <input type="checkbox"/> No Age at Menopause: _____
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Signature of Patient (or Parent/Legal Guardian if Patient is a Minor): _____

Printed Name of Patient: _____ DOB: _____

Date: _____

Relationship to Patient (if applicable): _____