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 #:*	*Relationship:*
Name:	*Phone #:*	*Relationship:*
Name:	*Phone #:*	*Relationship:*
Name:	*Phone #:*	*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: _____

Preferred pharmacy:_____

PATIENT MEDICAL HISTORY		PATIENT REVIEW OF SYSTEMS	
Please **circle** any medical problem(s) you have had in the past or may currently have.		Please **circle** any symptoms below you may currently have.	
Anemia	GERD	Abdominal bloating	Poor appetite
Barrett's esophagus	Hemorrhoids	Abdominal pain	Rectal bleeding/pain
Bleeding/Clotting problems	Hepatitis B/Hepatitis C	Blood in stool	Nausea/Vomiting
Cirrhosis	HIV/AIDS	Blood with urination	Trouble swallowing
C. diff	Immune deficiency	Change in bowel habit	Weight loss
Colon cancer	Inflammatory bowel disease	Chest pain	Other:
Colon polyps	Kidney disease/stones	Constipation	
Crohn's disease	Liver cancer	Diarrhea	
Diabetes	Liver disease	Heartburn	
Diverticulitis	Organ transplant	Hemorrhoids	
Esophageal cancer	Pancreatic cancer	Indigestion	
Gastric ulcers	Weight loss	Inability to control bowels	
Gallbladder disease	Other:	Inability to control urination	

PATIENT SOCIAL HISTORY		
Please **circle** below and provide frequency of use:		
Smoking/tobacco – Frequency: _____	Live with someone who smokes: Yes or No	Former smoker: Yes or No
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.		
Colonoscopy	EGD	Hysterectomy
Colostomy	Hernia repair	Weight loss surgery
Colon resection	Hemorrhoidectomy	**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
Anemia		Gallbladder disease	
Barrett's esophagus		HIV/AIDS	
Bleeding/Clotting problems		Immune deficiency	
Colon cancer		Kidney disease/stones	
Crohn's disease		Liver cancer	
Diabetes		Liver disease	
Esophageal cancer		Pancreatic cancer	

Patient Signature:_____Date:_____