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 #:*	*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: _____ Date: _____

Please list the reason for your visit: _____

Do you currently or have you ever had (please check all that apply):

	Angina (chest pain that comes and goes)		Congestive heart failure (CHF)		High blood pressure
	Heart attack		Stroke (CVA or TIA)		Atrial fibrillation
	COPD		Asthma		Emphysema
	Irritable bowel syndrome (IBS)		Diverticulitis		Type 2 Diabetes Mellitus
	Kidney failure/dialysis		Seizures		Type 1 Diabetes Mellitus
	Colon cancer		Stomach ulcers		GERD (reflux)
	Liver disease		Hepatitis		HIV
	Breast Cancer		Any cancer (please list):		

If you have been in the hospital for anything other than after surgery, please list the reason for admission below:

_____

Surgeries (please check all that apply and fill in the date the surgery was performed):

√	**Surgery**	**Year**	√	**Surgery**	**Year**	√	**Surgery**	**Year**
	Open heart			Heart stents			Hysterectomy	
	Appendectomy			C section			Removal of ovaries	
	Gallbladder			Colon surgery			Hernia repair	
	Tonsillectomy			Tubal ligation				
	Other (please list):							

Family History (please place a check in all boxes that apply):

	High Blood Pressure	Diabetes Mellitus	High Cholesterol	Heart Attack	Stroke	Cancer (type)
Father						
Mother						
Brother						
Sister						
Child						

Social History (please check the appropriate answer):

Yes	**No**	
		Do you currently smoke? If so, how many packs per day:
		Have you smoked in the past? If so, what year did you quit:
		Do you drink liquor, beer or wine? If so, how many drinks per day:
		Do you use illegal drugs (marijuana, cocaine, methamphetamine, etc)? If so, what?

Screening Exams:

Yes	**No**		
		Have you had a colonoscopy? If so, what year:	Where was it done:
		Have you had a mammogram? If so, what year:	Where was it done:

Patient Name: _____ DOB: _____ Date: _____

Please list current pharmacy: _____

Medications (please list all medications you are currently taking, including herbal supplements):

Medication Name	Dose (mg, mcg, etc)	Frequency (daily, twice a day, etc)

If you are under contract for chronic pain management, please list your physician: _____

****Please note that if you are under contract with a Pain Management physician we will contact their office for coordination of care should you require post-operative pain medications, per our pain medication policy. ****

Allergies (please list any allergies you have and the reaction):

Allergy	Reaction

I attest that the information above is correct to the best of my ability.

Patient signature: _____ Date: _____

Staff signature: _____ Date: _____

Revised: 4/19/2018

Patient Name: _____ DOB: _____ Date: _____

CONTROLLED SUBSTANCE POLICY

Due to changes in state regulations for controlled substances it has become necessary to develop a policy for controlled substances prescribed by this office.

First and foremost this does not create a contract by which there will be any obligation for the office to prescribe controlled substances. This office is not registered with the state as a prescriber for **chronic** nonmalignant pain. That means the doctor cannot prescribe pain medicine beyond the normal post-operative period.

We will be treating your pain as a result of surgery, not other chronic problems such as back pain.

We do not write prescriptions to "replace" medicine that you may have "borrowed" from spouse, friend etc. That is both illegal and dangerous and we do not condone it.

Controlled substances are to be controlled. We will not replace prescriptions that have been lost, stolen or for any other reason not in your possession.

It is illegal for a patient to receive controlled substances from more than one physician at a time. It could also result in the dismissal from the practice.

We reserve the right to drug test if there is suspected abuse or diversion of your pain medication.

We do not refill medication outside the regular office hours.

If you are under the care of a pain management doctor you must list it on the history form. Failure to do so could result in dismissal from this practice and possibly breach your contract with the pain management doctor. We will notify the pain management doctor that you are a patient of this office if we need to prescribe pain medicine.

We do not refill medication at the request of family members.

Many narcotics such as Lortab and Percocet contain acetaminophen (Tylenol); avoid taking other forms of Tylenol while on pain medicine.

If you want a copy of this policy please ask the receptionist.

Patient Name: _____ DOB: _____ Date: _____

Please place a check beside any symptoms that you are currently experiencing:

	Chills		Fever
	Weight loss		Rash
	Yellowing of skin		Breast lump
	Nipple discharge		Breast pain
	Vision changes		Hearing Loss
	Sore throat		Trouble swallowing
	Cough		Shortness of breath
	Wheezing		Shortness of breath when you lay down
	Chest pain		Leg swelling
	Pain in legs when walking		Irregular heartbeat
	Abdominal pain		Constipation
	Diarrhea		Nausea
	Vomiting		Black tarry stools
	Change in bowel habits		Blood in stools
	Indigestion/heartburn		Pain with urination
	Change in bladder habits		Dizziness
	Difficulty walking/loss of balance		Anxiety
	Depression		Pain in joints
	Back pain		Muscle weakness
	Bruise easily		Night sweats

I attest that the above information is accurate to the best of my ability.

Patient signature: _____ Date: _____