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 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)

Medical History Form

Name _____ Date of Birth ___/___/_____

Chief Complaint (current symptoms)
1. _____
2. _____
3. _____

Immunizations and Wellness: Please list month and year of last

Vaccines: Tetanus ___/____ Flu ___/____ Pneumonia ___/____ Shingles ___/____

Diabetics: Dilated Eye Exam ____/____ Foot Exam ____/____

Over 50: Colonoscopy ___/____ Bone Density Test ___/____

Female: Mammogram __/____ Pap Smear __/____ Abnormal? ☐ Yes ☐ No

Contraception Type
- ☐ Vasectomy
- ☐ IUD Year ____
- ☐ Pill
- ☐ Tubal
- ☐ Condoms
- ☐ Depo
- ☐ Other _____

Last Menstrual Period ___/___/_____

Pregnancies _____
Miscarriages _____
Abortions _____
Deliveries _____

Hysterectomy?
- ☐ Yes
- ☐ No

Reason? _____

Male: PSA ___/____

Past Medical History: Please check all that apply

	Yes		Yes		Yes
Allergies	☐	Diabetes	☐	Seizure Disorder	☐
Anemia	☐	Heart Arrhythmia/Palpitations	☐	Sexually Transmitted Infection	☐
Anxiety Disorder	☐	Heart Attack or Bypass Surgery	☐	Stomach Ulcer	☐
Arthritis	☐	Heart Disease	☐	Stroke	☐
Asthma	☐	High Blood Pressure	☐	Thyroid disorder	☐
Birth Defects	☐	High Cholesterol	☐	Other: _____	☐
Blood Clots	☐	Kidney Disease	☐	_____	
Blood Transfusion	☐	Liver Disease	☐	_____	
Bone Fracture	☐	Osteoporosis	☐	_____	
Cancer: Type	☐	Reflux	☐	_____	
Depression	☐	Respiratory Disease (e.g. COPD)	☐	_____	

Surgical History: Please list any surgeries you have had and the month and year

1. _____ Date ___/____
2. _____ Date ___/____
3. _____ Date ___/____
4. _____ Date ___/____
5. _____ Date ___/____
6. _____ Date ___/____

Name _____ Date of Birth ___/___/_____

Family History					
	Who		Who		Who
Blood Clots	☐ Mother ☐ Grandparent ☐ Father ☐ Maternal ☐ Sister ☐ Paternal ☐ Brother	Diabetes	☐ Mother ☐ Grandparent ☐ Father ☐ Maternal ☐ Sister ☐ Paternal ☐ Brother	Prostate Cancer	☐ Mother ☐ Grandparent ☐ Father ☐ Maternal ☐ Sister ☐ Paternal ☐ Brother
Breast Cancer	☐ Mother ☐ Grandparent ☐ Father ☐ Maternal ☐ Sister ☐ Paternal ☐ Brother	Heart Disease	☐ Mother ☐ Grandparent ☐ Father ☐ Maternal ☐ Sister ☐ Paternal ☐ Brother	Stroke	☐ Mother ☐ Grandparent ☐ Father ☐ Maternal ☐ Sister ☐ Paternal ☐ Brother
Colon Cancer	☐ Mother ☐ Grandparent ☐ Father ☐ Maternal ☐ Sister ☐ Paternal ☐ Brother	Osteoporosis or Hip Fracture	☐ Mother ☐ Grandparent ☐ Father ☐ Maternal ☐ Sister ☐ Paternal ☐ Brother	Other	☐ Mother ☐ Grandparent ☐ Father ☐ Maternal ☐ Sister ☐ Paternal ☐ Brother
Depression	☐ Mother ☐ Grandparent ☐ Father ☐ Maternal ☐ Sister ☐ Paternal ☐ Brother	Ovarian Cancer	☐ Mother ☐ Grandparent ☐ Father ☐ Maternal ☐ Sister ☐ Paternal ☐ Brother	☐ Other _____	

Father	Age (if living) _____	Age at death (if deceased) _____
Mother	Age (if living) _____	Age at death (if deceased) _____
Sibling	Age (if living) _____	Age at death (if deceased) _____
Sibling	Age (if living) _____	Age at death (if deceased) _____
Sibling	Age (if living) _____	Age at death (if deceased) _____

Social History					
Tobacco Use	☐ Never	Current	Packs per day _____	Year began ____	Type ☐ Cigarettes ☐ Chew ☐ Pipe ☐ Cigars ☐ E-Cigarettes
		Former	Packs per day _____	Year began ____	
Alcohol Use	☐ Never	Current	Drinks per day ____ per month ____ per year ____		Type ☐ Beer ☐ Wine ☐ Liquor ☐ Other _____
			Year began _____		
		Former	Drinks per day ____ per month ____ per year ____		Type ☐ Beer ☐ Wine ☐ Liquor ☐ Other _____
			Year began _____		
Caffeine	☐ Never	☐ Yes	Amount per day _____		Type _____
Exercise	☐ Never	☐ Yes	Sessions per week _____		Type _____

Medications and Allergies

Name _____ Date of Birth ___/___/_____

Pharmacy Name _____ Mail Order _____

Allergies

Please list any allergies to medications or foods. Example of reactions: rash or hives, trouble breathing, nausea, etc.

Name	Reaction	Name	Reaction
1.		7.	
2.		8.	
3.		9.	
4.		10.	
5.		11.	
6.		12.	

Medications

If you bring your medication bottles to your appointment, please skip this section.

Name	Dose	Frequency

Review of Systems

Name _____ Date of Birth ___/___/_____

Please check Yes or No if you are currently experiencing any of the symptoms below:

Y	N	General	Y	N	Skin	Y	N	Breast
☐	☐	Decreased Appetite	☐	☐	Dry Skin	☐	☐	Breast Lump
☐	☐	Chills	☐	☐	Itching	☐	☐	Nipple Discharge
☐	☐	Fever	☐	☐	Redness	☐	☐	Nipple Retraction
☐	☐	Malaise/Fatigue	☐	☐	Rash	☐	☐	Tenderness
☐	☐	Weight Loss	☐	☐	Skin Color Changes	☐	☐	Swollen Glands
☐	☐	Weight Gain	☐	☐	Mole Changes	☐	☐	Swelling
			☐	☐	Open Sores/Wounds	☐	☐	Nipple Pain
						☐	☐	Recent Breast Size Changes

Y	N	Eye	Y	N	Ear	Y	N	Nose
☐	☐	Itching	☐	☐	Discharge	☐	☐	Congestion
☐	☐	Tearing/watering	☐	☐	Hearing Loss	☐	☐	Nose Bleeds
☐	☐	Pain	☐	☐	Pain	☐	☐	Sneezing
☐	☐	Sensitivity to Light	☐	☐	Ringing in Ears	☐	☐	Decreased Sense of Smell
☐	☐	Vision Changes	☐	☐	Pulling on Ear	☐	☐	Runny Nose
☐	☐	Discharge				☐	☐	Sinus Pain
☐	☐	Redness				☐	☐	Sinus Pressure
☐	☐	Dryness				☐	☐	Post Nasal Drip

Y	N	Mouth and Throat	Y	N	Respiratory	Y	N	Cardiovascular
☐	☐	Pain	☐	☐	Shortness of Breath	☐	☐	Chest Pain
☐	☐	Sore Throat	☐	☐	Shortness of Breath on Exertion	☐	☐	Claudication/Extremety Pain
☐	☐	Hoarseness	☐	☐	Shortness of Breath at Rest	☐	☐	Lower Extremity Swelling
☐	☐	Dryness	☐	☐	Cough	☐	☐	Orthopnea or Difficulty Breathing While Lying Down
☐	☐	Difficulty Swallowing	☐	☐	Sputum Production	☐	☐	Palpitation or Fast Heart Beat
☐	☐	Difficulty Chewing	☐	☐	Coughing Up Blood	☐	☐	Syncope or Fainting/Passing Out
☐	☐	Dental Problems	☐	☐	Wheezing	☐	☐	Lightheadedness/Dizziness
			☐	☐	Snoring	☐	☐	Diaphoresis or Excessive or Abnormal Sweating

Y	N	Gastrointestinal	Y	N	Genitourinary	Y	N	Neurological
☐	☐	Abdominal Pain	☐	☐	Dysuria - painful urination	☐	☐	Confusion
☐	☐	Rectal Pain	☐	☐	Urinary Frequency	☐	☐	Memory Loss
☐	☐	Diarrhea	☐	☐	Urinary Urgency	☐	☐	Dizziness
☐	☐	Nausea	☐	☐	Urinary Hesitancy	☐	☐	Headache
☐	☐	Vomiting	☐	☐	Change in Bladder Habits	☐	☐	Numbness
☐	☐	Black Tarry Stools	☐	☐	Urinary Incontinence or Urine Leakage	☐	☐	Generalized Weakness
☐	☐	Mucous in Stool	☐	☐	Sexual Dysfunction	☐	☐	Difficulty Speaking
☐	☐	Change in Bowel Habits	☐	☐	Penile Discharge	☐	☐	Difficulty with Ambulation
☐	☐	Stool Incontinence	☐	☐	Pain	☐	☐	Tingling
			☐	☐	Change in Menses	☐	☐	Loss of Balance
			☐	☐	Dyspareunia or Painful Intercourse	☐	☐	Unusual Sensation
			☐	☐	Vaginal Discharge	☐	☐	Radicular Symptoms
			☐	☐	Vaginal Pruritus or Itching	☐	☐	Rotational Symptoms
			☐	☐	Vulvar Swelling			

Y	N	Psychological	Y	N	Musculoskeletal	Y	N	Heme/Lymph
☐	☐	Anxiety	☐	☐	Arthralgia or Joint Pain	☐	☐	Bruising Easily
☐	☐	Depression	☐	☐	Joint Swelling	☐	☐	Enlarged or Tender Lymph Nodes
☐	☐	Hallucinations	☐	☐	Joint Redness	☐	☐	Night Sweats
☐	☐	Insomnia	☐	☐	Joint Stiffness	☐	☐	Abnormal Bleeding
☐	☐	Mood Problems	☐	☐	Neck Pain			
☐	☐	Fearful	☐	☐	Back Pain			
☐	☐	Suicidal Ideation Or Thoughts of Self Harm	☐	☐	Myalgia or Muscle Pain			
☐	☐	Homicidal Ideation Or Thoughts of Harming Others	☐	☐	Muscle Weakness			
☐	☐	Delusions						
☐	☐	Stress						

Y	N	Endocrine	Y	N	Allergic/Immunologic	Y	N	Other
☐	☐	Unusual Change in Weight	☐	☐	Environmental Allergies	☐	☐	
☐	☐	Cold or Heat Intolerance	☐	☐	Food Allergies	☐	☐	
☐	☐	Hot Flashes	☐	☐	Hay Fever	☐	☐	
☐	☐	Polydipsia or Extreme Thirst	☐	☐	HIV	☐	☐	
☐	☐	Polyuria or Excessive Urination	☐	☐	Latex Allergy	☐	☐	
☐	☐	Changes in Appetite	☐	☐	Immunologic Disorder	☐	☐	
			☐	☐	Immunosuppressive Disorder	☐	☐	