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)

Patient Name: _____Date:_____

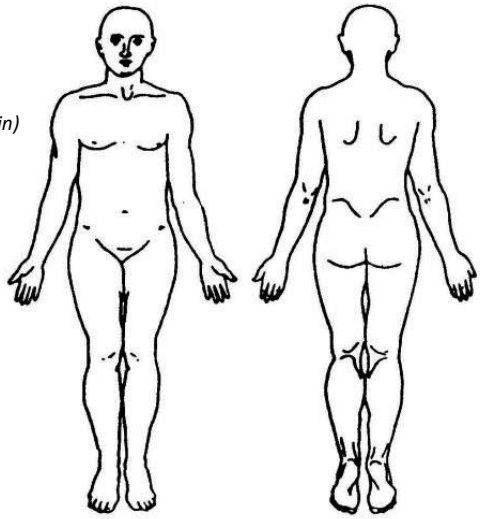
1. ___Right Handed ___Left Handed Occupation:_____
2. Reason for visit? _____
3. How long have you had these symptoms? _____

On a scale of 1 to 10, with 10 being the **WORST** pain you can imagine and 1 being essentially pain free, how would you rate your typical pain on a daily basis? *(Circle the number below)*

1 2 3 4 5 6 7 8 9 10

(Pain Free) *(Worst Pain)*

*Please indicate **where** your pain is located by drawing on the diagram:



(Please circle your answers to the questions below)

4. Have you seen another Neurosurgeon? Yes No If yes, who & when? _____
5. Have you tried **Physical Therapy** in the last 12 months? YES NO
   If yes, when was your first visit? _____ Did your symptoms improve? YES NO
   ___Aquatics ___Ultrasound ___Massage ___Exercises ___Electrical Stim ___Ice/Heat ___Traction ___Manipulation
6. Have you tried **chiropractic treatment** in the last 12 months? YES NO
   If yes, how many visits? _____ Did your symptoms improve? YES NO
7. Have you received **epidural steroid injections** (pain blocks) in the last 12 months? YES NO
   If yes, how many have you had?_____ Did your symptoms improve? YES NO
8. Have you tried **pain management** for this condition? YES NO
   Pain Management Doctor: _____ Date first seen:_____
9. Are you taking any **narcotic pain medication** for your present condition? YES NO
   If yes, please list:_____
   If Yes, How long have you taken pain medication? _____Months _____Weeks _____Days
10. Have you received any other conservative treatment for your back? YES NO
    If yes, please list: _____
11. Have you had any cognitive, behavioral, or addiction issues identified? YES NO
    If yes, have you been treated? YES NO
12. Is there a chance you could be pregnant? YES NO
    Last Menstrual Period Date (if applicable):_____
13. Please place a check mark by medications you take currently or have taken **within the last 2 weeks**:
    ___Aspirin medications (Goody/BC powder, Excedrin) ___Anti-inflammatory meds (Aleve, Advil, Mobic)
    ___Coumadin ___Plavix ___Lovenox ___Pradaxa ___Xarelto ___Fish Oil ___Vitamin E ___Diet pills

These questions pertain to the ***patient only***.
Please check yes if you experience the problem currently or within the last 3 months.

Constitutional	**No**	**Yes**	**Metabolic/Endocrine**	**No**	**Yes**
Chills/rigors			Cold Intolerance		
Fatigue			Heat Intolerance		
Fever			Weight Gain		
Night Sweats					
Weight Loss			**Neuro/Psychiatric**	**No**	**Yes**
			Dizziness		
HEENT	**No**	**Yes**	Difficulty Speaking		
Headache			Weakness		
Infections			Trouble Walking		
Visual Loss			Incontinence (Loss of Bowel or Bladder)		
Facial Pain			Incoordination		
Difficulty Swallowing			Light-headedness		
			Loss of consciousness		
Respiratory	**No**	**Yes**	Memory Impairment		
Cough			Fainting Spells		
Difficulty Breathing			Numbness, Tingling		
Phlegm			Seizures		
			Speech Changes		
Cardiovascular	**No**	**Yes**	Tremors		
Chest Pain			Vertigo		
Swelling			Visual Changes		
Irregular Heartbeat/Palpitations					
			Dermatologic	**No**	**Yes**
Vascular	**No**	**Yes**	Contact Allergy		
Leg Cramps with Activity			Frequent Skin Infections		
Cool Extremity			Rash		
Blue Coloring to Extremity					
Skin Redness			**Musculoskeletal**	**No**	**Yes**
Raynaud's			Back Pain		
			Bone/Joint Symptoms		
Gastrointestinal	**No**	**Yes**	Muscle Pain		
Abdominal Pain			Muscle Weakness		
Change in Appetite			Neck Stiffness		
Constipation					
Diarrhea			**Hematologic**	**No**	**Yes**
Nausea			Easy Bleeding		
Vomiting			Easy Bruising		
			Blood Clots (leg, lung)		
Genitourinary	**No**	**Yes**			
Painful/Difficult Urination					
Frequent Urination					
Urinary Incontinence					

PATIENT & FAMILY HISTORY

BAPTIST MEDICAL GROUP

Place a check beside any medical problem(s) you have currently or have had in the past.
Place a check beside any problem(s) any family member (parents, grandparents, siblings) has currently or in the past.

	Patient	Family		Patient	Family
Anemia			Liver Disease		
Asthma/COPD			Neuropathy		
Bleeding Disorder			Organ Transplant (**specify**)_____		
Blood Clots (Leg/Lung)			Osteoarthritis or Rheumatoid Arthritis		
Cancer Type:_____			Peripheral Vascular Disease		
Depression			Pneumonia		
Diabetes			Psychiatric Illness (**specify**)_____		
Fibromyalgia			Reflux/GERD		
Glaucoma/Visual Loss			Seizure Disorder		
Hearing Loss			Steroid Use		
Heart (Circle): Heart Attack, Congestive Heart Failure, Irregular Heartbeat, Heart Murmur			Skin Ulcer/Breakdown/Wound Healing Problems		
Hepatitis B/C			Stomach Ulcers/Heartburn		
High Blood Pressure			Stroke		
HIV/AIDS			Thyroid Disease		
Immune Deficiency/STDs			Tuberculosis (TB)		
Kidney Disease/Stones			Urinary Problems		

List any medical problems not listed above: _____
_____

Pneumonia Vaccine?	Yes___	No___	Date:	Flu Vaccine?	Yes ___	No___	Date:

Do you have any **ALLERGIES? (medication, latex, environmental, or food) Yes ___ No___
If yes, please list: _____

List all medications you are taking, including over-the-counter and herbal supplements, or provide a list:

Medication	**Dosage** (mg)	How many times/day?	Prescribing MD
1.			
2.			
3.			
4.			
5.			
6.			
7.			

PAST SURGICAL HISTORY - List surgeries below, or provide a list:

Surgery	Date	Surgeon
1.		
2.		
3.		
4.		

Do you currently smoke tobacco? Yes___ No___ Former smoker?___ If yes, packs/day: _____ Years:_____
Smokeless tobacco? Yes___ No___ Former___
Alcohol? Yes ___ No___ How often? _____ Do you drink caffeine (coffee, soda, tea)? Yes___ No___

Patient Signature:	Date:
Provider Signature:	Date: