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In anticipation of your upcoming appointment, we would appreciate your attention to the following information:

- Please complete the enclosed paperwork in its entirety to ensure the most accurate records for our physicians. This includes an up to date medical list.
- Please arrive at least 30 minutes early so that we may verify your insurance, scan your cards, and have you ready to see the provider at your appointment time. Please make travel arrangements to be early to your appointment.
- If you are late to your appointment, we reserve the right to reschedule your appointment. This policy is per our providers to ensure a timely schedule for both the physician and our patients.
- It is the patient's responsibility to verify that the physician you are seeing is in network with the insurance plan you have. You can call the customer service number located on the back of your card to verify this.
- If you are to be treated for injuries sustained during a motor vehicle accident, please bring your automobile insurance car as well as your health insurance cards.
- Please provide our office with any pertinent X-ray, MRI, or CT reports, including any imaging disks. This is immensely helpful to the productivity of your appointment.
- Please keep in mind that an appointment with our office is not a guarantee of narcotics or opiates even if you are currently prescribed these medications by another physician.

**Helpful hints for our patients:**

- If your X-rays, MRIs, CTs, or any other scans were completed in a Baptist Health Care Facility, we will have access to those images and reports. You will not need to bring those items. Just kindly inform the front desk at check in and we will get those items for you.
- If you have additional medical records that you find pertinent to your care in our office, please bring them with you. We will be glad to add them to your records.
- We are happy to schedule you as a new patient with one of our physicians. Please be advised that our physicians will not prescribe narcotic medications on your first visit and they will evaluate you to determine if narcotic medications are appropriate during your appointment.

We look forward to meeting you at your upcoming appointment. Thank you for choosing Andrews Institute Physical Medicine and Rehabilitation.

APPOINTMENT DATE: _____TIME: _____ AM/PM

# 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 #: _____

## Past Medical History

Have you ever had any of the following? Please check all pertinent boxes.

- ☐ Aids or HIV +
- ☐ Anemia
- ☐ Arthritis
- ☐ Bleeding Tendency
- ☐ Diabetes
- ☐ Blood Transfusions
- ☐ Cancer
- ☐ Epilepsy/Seizures
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Kidney Disease
- ☐ Mitral Valve Prolapse
- ☐ Stroke
- ☐ Tuberculosis

## Past Surgical History

Please list all previous Orthopedic Surgeries and Serious Illnesses | When? | Hospital, City, State

_____

_____

_____

_____

_____

## Medications

Please include non-prescription and Herbal Supplements:

| Drug Name | Dosage | Frequency | Drug Name | Dosage | Frequency |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

## Allergies

| Medication | Reaction | Medication | Reaction |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## Family History

Please check all pertinent boxes.

- ☐ Back Pain
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Stroke
- ☐ Sudden Death
- ☐ Tuberculosis

## Patient Social History

Please check all pertinent boxes.

### Marital Status

- ☐ Divorced
- ☐ Married
- ☐ Separated
- ☐ Single
- ☐ Widowed

### Use of Alcohol

- ☐ Daily
- ☐ Moderate
- ☐ Never
- ☐ Rarely

### Use of Tobacco

- ☐ Currently
- ☐ Never
- ☐ Previously, but quit

Packs Per Day: ____

### Dominant Hand

- ☐ Right
- ☐ Left

BAPTIST MEDICAL GROUP

## 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*)



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