Patient Registration Form

Last Name _____ First Name _____ MI ___

Social Security ___ - ___ - ____

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
- ☐ Legally Sep
- ☐ Life Partner
- ☐ Married
- ☐ Single
- ☐ Widowed
- ☐ Unknown

Date of Birth ___/___/_____

Address _____ City _____ State _____ Zip _____

Email _____

Primary Phone (____) _____ - _____ Secondary 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

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 ___/___/_____ Sex ☐ 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)

PATIENT HISTORY FORM

Name:_____ Date of Birth:_____

Social Security #:_____ Referring Physician:_____

Reason for Referral:_____

PHYSICIANS **List all doctors providing care**

Doctor's Name	Type of Doctor *Primary Care, Surgeon, Urologist, etc.*	Reason for seeing this doctor

ALLERGIES **Do you have allergies to drugs, food, seafood, latex, dye?** ☐ **Yes** ☐ **No**

Allergy to:	Reaction- rash, shortness of breath, hives, itching, etc.

CURRENT MEDICATIONS

List all vitamins, prescription medications, and over-the-counter medications

★ **Bring ALL MEDICATION in their original containers to every appointment.**

Medication name	Dosage	How often do you take?	Prescribing Physician

PAST MEDICAL & SURGICAL HISTORY

EENT
- □ Cataracts
- □ Diabetic Retinopathy
- □ Glaucoma
- □ Macular Degeneration
- □ Retinal Detachment
- □ Sinusitis
- □ Tinnitus
- □ Tonsillitis
- □ Other: _____

Respiratory
- □ ARDS (Adult Resp. Distress Syndrome)
- □ Asthma
- □ COPD
- □ Pneumonia
- □ Pulmonary Embolus (clot)
- □ Pulmonary Hypertension
- □ Sleep Apnea, CPAP
- □ Tuberculosis
- □ Other: _____

Cardiac
- □ Arrhythmias
- □ Cardiomyopathy
- □ Congestive Heart Failure
- □ Coronary Artery Disease
- □ Hypertension
- □ Myocardial Infarction (heart attack)
- □ Sudden Death
- □ Valvular Heart Disease
- □ Other: _____

Vascular
- □ Aortic Aneurysm
- □ Carotid Disease
- □ Claudication
- □ DVT
- □ Peripheral Vascular Disease
- □ Phlebitis
- □ Raynaud's
- □ Varicose Veins
- □ Other: _____

Gastrointestinal
- □ Cirrhosis
- □ GERD
- □ Hepatitis
- □ Hiatal Hernia
- □ Pancreatitis
- □ Peptic Ulcer Disease
- □ Ulcerative Colitis
- □ Other: _____

Renal/GU
- □ Bladder Cancer
- □ BPH (enlarged prostate)
- □ End Stage Renal Disease
- □ Kidney Stones
- □ Prostate Cancer
- □ Prostatitis
- □ Renal Artery Stenosis
- □ Renal Failure
- □ Renal Insufficiency
- □ Other: _____

GYN
- □ Benign Breast Lump
- □ Breast Cancer
- □ Cervical Cancer
- □ Ovarian Cancer
- □ Other: _____

Musculoskeletal
- □ Back Pain
- □ Gout
- □ Lupus
- □ MVA Trauma
- □ Rheumatoid Arthritis
- □ Other: _____

Skin
- □ Cellulitis
- □ Hives
- □ Psoriasis
- □ Scleroderma
- □ Skin Cancer
- □ Other: _____

Neurologic
- □ Alzheimer's Disease
- □ CVA
- □ Dementia
- □ Diabetic Neuropathy
- □ Fibromyalgia
- □ Migraines
- □ Multiple Sclerosis
- □ Parkinson's Disease
- □ Seizure Disorder
- □ Syncope
- □ TIA
- □ Other: _____

Psychiatric
- □ Alcoholism
- □ Anorexia
- □ Bipolar Disorder
- □ Chronic Anxiety
- □ Depression
- □ Panic Disorder
- □ Post-Traumatic Stress Disorder
- □ Other: _____

Hematologic
- □ Anemia
- □ Other: _____

Endocrine
- □ Diabetes
- □ Thyroid
- □ Other: _____

Infectious Disease
- □ Endocarditis
- □ HIV
- □ Other: _____

Recent Hospitalizations

□ Yes □ No

List Hospital/Date/Reason for hospitalization: _____

_____

_____

_____

Cardiac Surgeries & Procedures

- □ Cardiac Cath Year _____
- □ Cardioversion Year _____
- □ Coronary Angioplasty/Stent Year _____
- □ Coronary Artery Bypass Year _____
- □ EP Study Year _____
- □ ICD Placement Year _____
- □ Pacemaker Implant Year _____
- □ RF Ablation Year _____
- □ Heart Valve Repair/Replaced Year _____
- □ Other: (List Below) Year _____

_____

_____

_____

Other Surgeries & Procedures

- □ Aneurysm Repair Year _____
- □ Appendectomy Year _____
- □ Back surgery Year _____
- □ Carotid Surgery Year _____
- □ Cholecystectomy (Gallbladder removed) Year _____
- □ Gastric Bypass Year _____
- □ Hysterectomy Year _____
- □ Kidney Stone Treatment Year _____
- □ Knee Surgery Year _____
- □ Mastectomy Year _____
- □ Nephrectomy (Kidney removed) Year _____
- □ Tonsillectomy Year _____
- □ Thyroidectomy Year _____
- □ Other: _____ Year _____

SOCIAL & FAMILY HISTORY

Alcohol Use
Do you consume alcohol
□ Yes □ No □ Former
Frequency:
_____
Year quit: _____

Smoking/Tobacco Use
Do you smoke/use tobacco?
□ Yes □ No □ Former
Type: □ Cigarettes □ Pipe
□ Cigar □ Smokeless
Number of years smoked: _____
Packs per day: _____
Years quit: _____
Passive Smoke Exposure:
□ Yes □ No

Diet
Are you on a special diet? □ Yes □ No
What type of diet? _____
_____
Do you drink caffeine? □ Yes □ No
How much a day? _____
Do you eat much chocolate a day?
□ Yes □ No

Exercise
Do you exercise regularly?
(minimum of 30 minutes/3 times a week)
□ Yes □ No
If YES describe: _____
Religion: _____
Agree to Transfusion □ Yes □ No

Drug Use/Abuse
□ Yes □ No □ Former
Substance type: _____
Years quit: _____
Marital Status: _____
Occupation
List: _____
□ Unemployed □ Retired
Residence
Live with: _____
□ Nursing home □ Assisted Living
Advanced Directives
□ None □ DNR
□ HC Proxy
□ Living Will Date: _____

Is there a Family History of: **(List All Family Members):**

Heart Attack	□	□	Family Member _____
Stroke	□	□	Family Member _____
Coronary Bypass Surgery	□	□	Family Member _____
Diabetes	□	□	Family Member _____
High Blood Pressure	□	□	Family Member _____
Coronary Artery Disease	□	□	Family Member _____
Sudden Death	□	□	Family Member _____

REVIEW OF SYSTEMS *Check if you are experiencing any of the symptoms listed below.*

General
□ Decreased appetite
□ Fever
□ Chills
□ Weight change (Loss or Gain)
□ Night sweats
□ Fatigue

HEENT
□ Headache
□ Glaucoma
□ Cataracts
□ Double vison
□ Blurred vision
□ Ringing in ears
□ Hearing loss
□ Hoarseness
□ Nosebleeds

Respiratory
□ Persistent cough
□ Shortness of breath with rest
□ Shortness of breath with activity
□ Snoring
□ Coughing up blood
□ Wheezing
□ # of pillows used to sleep on _____

Cardiovascular
□ Chest pain, pressure or tightness
□ Passing out
□ Heart palpitations
□ History of blood clots or phlebitis
□ Irregular heart beats
□ Non-healing sores on legs or feet
□ Pain in legs/hips with walking
□ Shortness of breath lying flat
□ Swelling of feet or ankles
□ Waking up panicky & short of breath
□ Dizziness

Gastrointestinal
□ Nausea and vomiting
□ Nausea without vomiting
□ Diarrhea
□ Constipation
□ Heartburn/Indigestion
□ Rectal bleeding
□ Black tarry stools
□ Difficulty swallowing solids/liquids

Endocrine
□ Excessive thirst
□ Increased urination
□ Hair loss

Hematological
□ Bleed easily
□ Bruise easily

Neurological
□ Headaches
□ Numbness/tingling on one side
□ Weakness on one side
□ Difficulty speaking
□ Loss of memory

Musculoskeletal
□ Muscle weakness
□ Joint stiffness
□ Arthritis
□ Gout
□ Muscle cramps

Genitourinary
□ Blood in urine
□ Pain with urination
□ Frequency of urination
□ Urgency of urination
□ Incontinence

Males:
□ Difficulty starting stream
□ Wake up at night to urinate
□ History of urinary retention
□ Prostate problems
□ Erectile dysfunction

Females:
Date of last menstrual period: _____
□ Currently on Birth Control
Menopause: □ Yes □ No
Age at Menopause: _____

Signature of Patient (or Parent/Legal Guardian if Patient is a Minor): _____

Printed Name of Patient: _____DOB:_____
Date: _____
Relationship to Patient (if applicable):_____