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)

ENDOCRINOLOGY

Name: _____

Date of Birth: _____

Patient History

Please check the box if you have received the following vaccinations and when they were given: ☐ Influenza (Flu): _____ ☐ Pneumovax (Pneumonia): _____ ☐ Tetanus: _____	
Have you ever received a blood transfusion? ☐ Yes ☐ No Date: _____	
Please indicate any blood relative who have/had the following conditions: Diabetes _____ High Blood Calcium _____ Osteoporosis _____ Hypertension _____ Pituitary disease _____ Autoimmune disease _____ Heart disease _____ Adrenal gland disease _____ Cancer _____ Thyroid Cancer _____ Infertility problems _____ Obesity _____ Thyroid disease _____ Kidney stones _____	
Occupation	☐ Full-time ☐ Part-time ☐ Retired ☐ Disabled ☐ Student ☐ Unemployed
Do you have any learning barriers?	☐ Vision ☐ Hearing ☐ Reading ☐ Language
Marital Status	☐ Single ☐ Married ☐ Partner ☐ Separated ☐ Divorced ☐ Widowed
Do you have a legal guardian or Healthcare Power of Attorney?	☐ Yes ☐ No Who? _____
Do you use any forms of tobacco now or in the past? Are you exposed to smoke at home or work?	☐ Yes ☐ No ☐ Yes ☐ No
Do you drink alcohol? Have you ever been treated for drug or alcohol abuse or dependence?	☐ Yes ☐ No ☐ Yes ☐ No
Do you use marijuana or recreational drugs? Have you ever shared the use of needles or use illicit drugs?	☐ Yes ☐ No ☐ Yes ☐ No
Are you sexually active?	☐ Yes ☐ No
Do you exercise regularly?	☐ Yes ☐ No How many times a week? _____

Associated Providers

Specialist/ Name If applicable, list the following:	**Address**	**Phone Number** **Fax Number**
Name _____		P: _____ F: _____
Name _____		P: _____ F: _____
Name _____		P: _____ F: _____
Name _____		P: _____ F: _____
Name _____		P: _____ F: _____