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 #:*	*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*)

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

_____

(Patient Last Name) **(First)** **(Middle)**

SS#: _____ Date of Birth: _____Telephone #: _____MR#_____

1. I hereby authorize the following person(s) / entity:

_____
(Name of Entity/Individual/Class of Persons)

_____
(Address)

_____
(City/State/Zip)

_____ _____
Phone Fax

To release to:

Baptist Medical Group Pre Optimization
1717 North E Street, STE 113
Pensacola, FL 32501
P:850.437.8730
F:850.437.8739

2. I authorize the following types of information to be released:
☐ General Medical ☐ HIV/AIDS (May not apply to Labs) ☐ Substance Abuse ☐ Psychiatric ☐ Psychotherapy Notes

3. I authorize the following types of records to be released: (check all that apply)
☐ General Abstract (includes Face Sheet, Discharge Summary, History & Physical, Operative Report, Pathology, and Consultation Reports)
☐ Face Sheet ☐ Pathology ☐ Cardiology Reports ☐ Other: (please specify below)
☐ Discharge Summary ☐ Consultations ☐ Radiology Reports
☐ History & Physical ☐ Labs ☐ Radiology Film _____
☐ Operative Report ☐ ER Record (Type: _____)

4. I authorize the following date(s) of service to be released: _____

5. This information is needed for the following purpose(s):
☐ Continued Care ☐ Insurance Claim ☐ Other: _____
☐ Personal Use ☐ Legal Purposes

6. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Facility Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event or condition:**

_____
If I fail to specify an expiration date, event, or condition, the authorization will expire within **12 months**.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this authorization in order to assure treatment. I understand that I may inspect a copy of the information to be used or disclosed, as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by Federal or State Privacy Laws. If I have questions about disclosure of my protected health information, I can contact the BHC Privacy Officer at (850) 434-4472. I also understand that obtaining medical information under false pretenses is a Federal and State crime, punishable by up to 10 years in prison.

8. If present, alcohol and drug abuse information has been disclosed from records whose confidentiality is protected by Federal law. Federal regulations 42CFR, Part2, prohibit making any further disclosure of records without the specific written authorization of the person to whom it pertains or as otherwise permitted by law.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If Signed by Legal Representative, Relationship to Patient Signature of Witness

Review of Systems: Please circle any of the symptoms you are having.

Constitutional: • Fatigue • Fever • Night sweats • Weight gain • Weight loss	**GI:** • Abdominal pain • Blood in stools • Constipation • Diarrhea • Heartburn • Loss of appetite • Nausea • Vomiting	**Psychiatric:** • Anxiety • Depression • Insomnia • Thoughts of suicide
Eyes: • Eye discharge • Eye pain • Change in vision	**Urinary:** • Dribbling • Pain w/ urination • Blood in urine • More frequent urination • Leaking urine	**Skin** • Itching • Changing mole • Rash
Ear, Nose, Throat: • Ear drainage • Ear pain • Hearing loss • Nasal Drainage • Sinus Pressure • Sore Throat	**Female Reproductive:** • Abnormal pap smear • Irregular periods • Heavy periods • Painful periods • Vaginal discharge • Breast discharge • Breast lump	**Muscle and Bones:** • Back pain • Joint pain • Joint swelling • Muscle pain or weakness
Respiratory: • Cough • Coughing up blood • Shortness of Breath • Wheezing	**Endocrine:** • Excessively hot or cold • Increased body hair • Increased thirst	**Blood and Lymphatics:** • Easy bleeding • Easy bruising • Swollen lymph nodes • History of DVT / blood clots
Cardiac: • Chest pain • Swelling of the legs • Abnormal heart beat • Rapid heart beat	**Neurologic:** • Dizziness • Numbness • Headache • Memory loss • Seizures o	**Male Reproductive:** • Discharge • Pain or mass • Erectile problems • Hernia

If any, please provide information below.

Primary Care Provider: _____

Cardiologist:_____ Current Pharmacy: _____

Patient Health Questionnaire (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Nearly every day 3	More than half the days 2	Several days 1	Not at all 0
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				
Trouble falling or staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself--or that you are a failure or have let yourself or your family down				
Trouble concentrating on things, such as reading the newspaper or watching television				
Moving or speaking so slowly that other people could have noticed. Or the opposite-being so fidgety or restless that you have been moving around a lot more than usual				
Thoughts that you would be better off dead, or of hurting yourself in some way				

Over the last 2 weeks, how often have you been bothered by the following				
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column		+	+	+

Total Score (add your column scores)=_____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lciwe B. A brief measure for assessing generalized anxiety disorder. Arch lnern Med. 2006; 166: 1092-1097.

DISCHARGE PLANNING FORM

[PATIENT LABEL HERE]

Email Address: _____

Phone Number: _____

Date of Surgery: _____

Surgery Type: ☐ Total Knee Replacement ☐ Total Hip Replacement **Laterality:** ☐ Right

☐ Total Knee Revision ☐ Total Hip Revision ☐ Left

☐ Partial Knee Replacement

1. Who will be at home to assist you once you are discharged: _____

Does this person live with you? ☐ Yes ☐ No

2. On average, how far can you currently walk?

☐ 2 blocks or more (+/- rest) ☐ 1-2 blocks (+/- rest) ☐ Housebound (most of the time)

3. Which gait aid do you use (more often than not)?

☐ None ☐ Single-point cane ☐ Crutches, walker, or wheelchair

4. How many stairs are leading to your home? _____ How many stairs inside your home? _____

5. How often do you currently use community support (such as home health, meals on wheels, etc.)?

☐ None ☐ One time per week ☐ Two or more times per week

6. How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?

☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

If you are having a **knee replacement**, please specify the location you prefer to have physical therapy and we will schedule your first appointment for you.

Andrews Institute Rehabilitation Locations:

Pensacola- ☐ University Pkwy/9 Mile Rd. ☐ Sorrento Road ☐ Bear Levin Studer Family YMCA

☐ Gulf Breeze ☐ North Okaloosa Medical Center ☐ Navarre ☐ Pace (Hwy 90) ☐ Jay

Encore Facility (please specify facility)**:** _____

Other (please specify facility)**:** _____