BAPTIST HEALTH®
MEDICAL GROUP

WELCOME TO _____

ADDRESS:	
PHONE:	
FAX:	
HOURS:	
AFTER-HOURS:	

Dear _____,

Thank you for trusting Baptist Health Medical Group with your care. Our team of physicians and staff are committed to providing you with the most advanced care in a comfortable, healing environment. Our goal is to make sure your visit goes as smoothly and pleasantly as possible.
Your appointment with _____ is scheduled on _____ at _____.

Enclosed in this new patient packet are the following:
- Patient forms to be completed prior to your visit.
- Policies and procedures.

We want to do our best to ensure the timeliness of your visit. In order to do so, we ask that you please arrive 30 minutes prior to your scheduled appointment time to complete your registration. Additionally, we ask that you bring any applicable items listed below.

- ✔ Attached forms completed in full.
- ✔ Photo ID.
- ✔ Insurance cards.
- ✔ Medications and supplements (in their original bottles).
- ✔ Any payment you may have (copayment, coinsurance, prepay).
- ✔ Medical records from your referring physician or CD of any radiology images.

We hope your experience at Baptist Health is a great one. Please feel free to call us at the phone number listed above if you have any questions, feedback or concerns about our office. We are dedicated to resolving your requests in a timely fashion, and strive to provide quality service and care to all our patients.

Sincerely,

_____

Your Healthcare Team at Baptist Health Medical Group

PATIENT DEMOGRAPHIC INFORMATION FORM

Please print legibly.

BAPTIST HEALTH® MEDICAL GROUP

Date: _____

Full Name: _____ Date of Birth: _____ SSN: _____
Age: _____ Sex: _____ Address: _____
City: _____ State: _____ Zip Code: _____
Home Ph: _____ Work Ph: _____ Cell Ph: _____
Email Address: _____ Marital Status: _____ Religion: _____
Ethnicity: ❑Hispanic/Latino ❑Non-Hispanic/Latino
Race: ❑White ❑Black/African American ❑Asian ❑Native American/Alaskan
❑Native Hawaiian/Pacific Islander
Preferred Language: _____ Written Language: _____ Needs Interpreter? ❑Yes ❑No
Do you have an Advanced Directive/Living Will? ❑Yes ❑No
Do you have a Power of Attorney? ❑Yes ❑No
Special Accommodations (Select as many that apply): ❑Hearing ❑Visual ❑Speech
❑Other _____
Are you a veteran? ❑Yes ❑No
Employment Status: ❑Full Time ❑Part Time ❑Not Employed ❑Military Duty ❑Self-Employed
❑Disabled ❑Student Full Time ❑Student Part Time ❑Retired
Employer: _____ Ph: _____
Employer Address: _____
Primary Physician (First and Last name): _____ Ph: _____
Referring Physician (First and Last name): _____
Emergency Contact: _____ Relationship: _____
Ph: _____

Guarantor Information: (Information of person financially responsible)
❑Same as patient-Skip to Insurance/Subscriber section
Guarantor Name:_____ Relationship to Patient:_____
Address: _____
City: _____ State: _____ Zip Code: _____
SSN: _____ Sex: _____ Date of Birth: _____
Home Ph: _____ Work Ph: _____ Cell Ph: _____
Employment Status: ❑Full Time ❑Part Time ❑Not Employed ❑Military Duty ❑Self-Employed
❑Disabled ❑Student Full Time ❑Student Part Time ❑Retired
Guarantor Employer: _____ Ph: _____
Address: _____

Insurance/Subscriber Information
Primary Insurance: _____ Plan (E.g. PPO, HMO): _____
Member ID #: _____ Claims Address: _____
Subscriber Name: _____ Patient Relationship to Subscriber: _____
Group #: _____ Subscriber SSN: _____
Subscriber Sex: _____ Subscriber Date of Birth: _____
Subscriber Address: _____
Employment Status of Subscriber: _____ Employer Name: _____
Ph: _____ Address: _____

Patient Name: _____ Date of Birth: _____

Secondary Insurance: _____ Plan (E.g. PPO, HMO): _____
Member ID #: _____ Claims Address: _____
Subscriber Name: _____ Patient Relationship to Subscriber: _____
Group #: _____ Subscriber SSN: _____
Subscriber Sex: _____ Subscriber Date of Birth: _____
Subscriber Address: _____
Employment Status of Subscriber: _____ Employer Name: _____
Ph: _____ Address: _____

Patient Name: _____ Date of Birth: _____

New Patient Information

Date: _____ Height: _____ Weight: _____

Family Physician: _____ Blood Pressure: _____ / _____

Consult Requested by: _____ HR: _____ Respirations: _____

Age: _____ R or L Handed

Employed: ❑ Yes ❑ No

History of Present Illness

What is the main reason for today's visit? _____

When did your symptoms begin? _____

Are your symptoms getting worse? _____

Does this pain/problem occur at a specific time? _____

Have you found anything that improves your symptoms? _____

Have you found things that make your symptoms worse? _____

Is there anything else you have found that is associated with your symptoms? _____

_____

Have you noticed a pattern with your symptoms? _____

Please list the name and address of your referring physician below. _____

_____

Please list the name and address of your primary care physician below. _____

_____

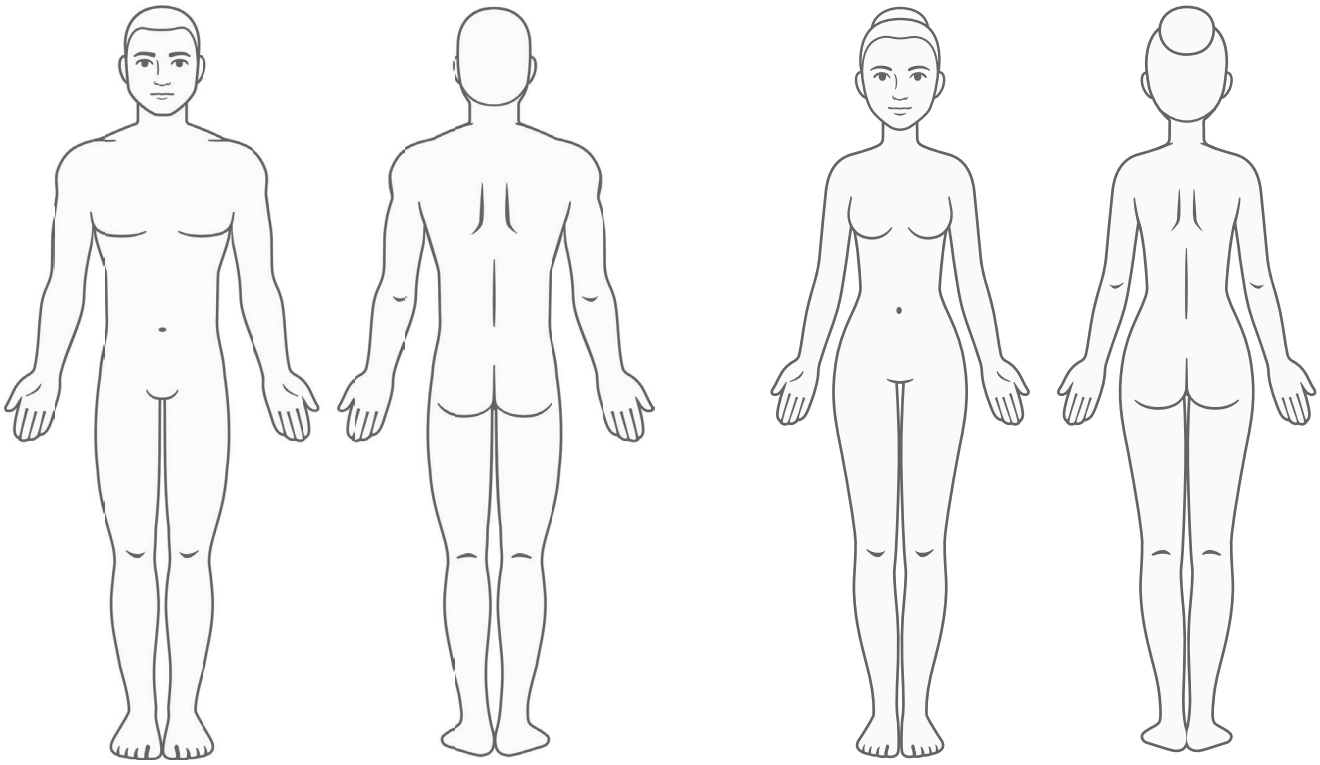
Have you been treated for this problem before? If so, how have you been treated? _____

Worked related injury: ❑ Yes ❑ No Date of injury: _____

Are you currently working? ❑ Yes ❑ No What is your occupation? _____

Motor vehicle accident injury: ❑ Yes ❑ No Date of injury: _____

Where is your pain? Please shade in area on figure below.



Patient Name: _____ Date of Birth: _____

Preferred Pharmacy: ❑Retail ❑Mail Order
Pharmacy Name:_____ Phone:_____
Address: _____
City: _____ State: _____ Zip Code: _____

Current Medications
Please list all prescriptions & over-the-counter medications, herbal drugs and vitamins (include dose & frequency):

Name of Drug/Medicine/ Vitamin	Dosage (If known)	How many Daily?	Name of Drug/Medicine/ Vitamin	Dosage (If known)	How many Daily?
1.			7.		
2.			8.		
3.			9.		
4.			10.		
5.			11.		
6.			12.		

Please list any drug allergies below:
1.
2.
3.
4.
❑N/A

Food and/or Other Allergies: (List all that apply.)
1. Latex: ❑Yes ❑No
2. _____
3. _____
4. _____
5. _____
6. _____

Immunization/Vaccination: (Check to indicate and list date received.)
❑Influenza _____
❑Pneumococcal _____
❑Shingles _____
❑Tetanus _____
❑Rubella_____

Patient Name: _____ Date of Birth: _____

Past Medical History: Check box if you have ever had the following:

❑AIDS/HIV
❑Anemia
❑Arthritis
❑Asthma
❑Back Problems
❑Bladder Infections
❑Bleeding
❑Bleeding Tendency
❑Blood Disease
❑Blood Transfusion (Reaction:❑Yes❑No)
❑Bronchitis
❑Cancer- _____
❑Claustrophobic
❑Convulsions
❑Diabetes (Sugar)
❑Emphysema
❑Epilepsy
❑Gout
❑Headache - Migraine
❑Hearing Loss
❑Heart Attack
❑Heart Disease
❑Heart Failure
❑Hernia
❑Hepatitis
❑High Blood Pressure
❑Hypertension
❑Kidney Disease
❑Osteoporosis
❑Pneumonia
❑Polio
❑Recent Infections
❑Rheumatic Fever
❑Seizures
❑Stroke
❑Thyroid Disease
❑Ulcers

Social History

Do you now, or have you ever used any tobacco? ❑Yes ❑No If so, what type? _____
How much per day? _____ For how many years?_____ When did you quit? _____

Do you drink alcohol? ❑Yes ❑No
How much per day? _____ Per week? _____
For how many years? _____ When did you quit? _____

Do you now, or have you ever used recreational drugs? ❑Yes ❑No If so, what kind? _____
How much per day? _____ Per month?_____
For how many years?_____ When did you quit? _____

Marital Status: ❑Single ❑Married ❑Divorced ❑Widowed

Patient Name: _____ Date of Birth: _____

Family History: List any significant illness in your immediate family members.

Indicate Family Member	Indicate Family Member
Arthritis, Gout	Heart Disease
Asthma, Hay Fever	High Blood Pressure
Cancer	Kidney Disease
Chemical Dependency	Tuberculosis
Diabetes	Other:

	Age	Disease	If deceased, cause of death
Father			
Mother			
Brother(s)			
Sister(s)			
Children			
Spouse			
Other *(Paternal Maternal relation)*			

Surgical History (including biopsies): List all operations with approximate dates or age.

Type	When	Location	Doctor
1.			
2.			
3.			
4.			
5.			
6.			

Patient Name: _____ Date of Birth: _____

Diagnostic Imaging History

Date	Type

Review of Systems: Please check box(es) if you are experiencing the following.

Constitution
❑Activity Change
❑Appetite Change
❑Chills
❑Diaphoresis
❑Fatigue
❑Fever
❑Unexpected Weight Change

HEENT
❑Congestion
❑Dental Problem
❑Drooling
❑Ear Discharge
❑Ear Pain
❑Facial Swelling
❑Hearing Loss
❑Mouth Sores
❑Nosebleeds
❑Postnasal Drip
❑Rhinorrhea
❑Sinus Pressure
❑Sneezing
❑Sore Throat
❑Tinnitus
❑Trouble Swallowing
❑Voice Change

Skin
❑Color Change
❑Pallor
❑Rash
❑Wound

Eyes
❑Discharge
❑Itching
❑Pain
❑Redness
❑Photophobia
❑Visual Disturbance

Respiratory
❑Apnea
❑Chest Tightness
❑Choking
❑Cough
❑Shortness of Breath
❑Stridor
❑Wheezing

Cardiovascular
❑Chest Pain
❑Leg Swelling
❑Palpitations

Gastrointestinal
❑Abdomen Distention
❑Abdominal Pain
❑Anal Bleeding
❑Blood in Stool
❑Constipation
❑Diarrhea
❑Nausea
❑Rectal Pain
❑Vomiting

Endocrine
❑Cold Intolerance
❑Heat Intolerance
❑Polydipsia
❑Polyphagia
❑Polyuria

Genitourinary
❑Difficulty Urinating
❑Dyspareunia
❑Dysuria
❑Enuresis
❑Flank Pain
❑Frequency
❑Genital Sore
❑Hematuria
❑Menstrual Problem
❑Pelvic Pain
❑Urgency
❑Urine Decreased
❑Vaginal Bleeding
❑Vaginal Discharge
❑Vaginal Pain

Musculoskeletal
❑Arthralgias
❑Back Pain
❑Gait Problem
❑Joint Swelling
❑Myalgias
❑Neck Pain
❑Neck Stiffness

Allergic/Immunologic
❑Environmental Allergies
❑Food Allergies
❑Immunocompromised

Neurological
❑Dizziness
❑Facial Asymmetry
❑Headaches
❑Light-headedness
❑Numbness
❑Seizures
❑Speech Difficulty
❑Syncope
❑Tremors
❑Weakness

Hematologic
❑Adenopathy
❑Bruises/Bleeds Easily

Psychiatric
❑Agitation
❑Behavior Problem
❑Confusion
❑Decreased Concentration
❑Dysphoric Mood
❑Hallucinations
❑Hyperactive
❑Nervous/Anxious
❑Self-injury
❑Sleep Disturbance
❑Suicidal Ideas

WRITTEN PRESCRIPTION RELEASE FORM

BAPTIST HEALTH®
MEDICAL GROUP

Dear Patient,

In order to release written prescriptions, including controlled substances; to someone other than you, it is necessary to have an authorization on file. This authorization allows you the opportunity to designate a specific person(s) to pick up any written prescription medication on your behalf. A valid photo ID must be presented each time prescriptions are picked up.

Please note written prescriptions will not be given to anyone who is not listed as an authorized individual. If at any time you would like to make changes to your approved list, you may do so by completing a new authorization form.

❑ I authorize the following individuals to pick up written prescriptions on my behalf from BHMG Neurosurgery.

Authorized Individual _____ Relationship to Patient_____

Authorized Individual _____ Relationship to Patient_____

Authorized Individual _____ Relationship to Patient_____

Authorized Individual _____ Relationship to Patient_____

❑ I do not authorize anyone other than myself to pick up my written prescriptions, including controlled substance prescriptions. I know that if I choose to allow another individual to pick up a written prescription for me, I must complete a new "Written Prescription Release Form".

Patient Name (Please Print): _____ DOB: _____

Patient Signature: _____ Date: _____

Parent or Guardian (Please Print): _____

Parent or Guardian Signature: _____ Date: _____

OFFICE POLICIES AND PROCEDURES

BAPTIST HEALTH®
MEDICAL GROUP

MyChart
Patients who sign up for MyChart will have free access to their Baptist Health medical records. Additional benefits of MyChart include the ability to schedule appointments, request prescription refills and send messages to your provider. To set up your account, provide your email address when registering for your appointment, or go to: https://mychart.baptisthealth.com.

Billing
Baptist Health files your assigned insurance claims for you as an additional service. Please remember that your insurance policy is a contract between you and the insurance company. You may need to contact your insurance company to resolve payment disputes. Payment for services is your responsibility and will be expected from you if insurance denies payment for services.

Patient Balances
Copayments (copays) are required the day of service. If your copay is not paid at the time of your visit, your appointment may be rescheduled. Self-pay patients are required to pay the day of service as well. If you have an outstanding balance, you will be expected to pay the balance, plus your copay or current visit charges, prior to seeing the provider. Other payment arrangements may be made prior to a visit in some circumstances. Outstanding accounts may be turned over to a collection agency.

Appointment Cancellation
Please give at least a 24-hour notice of cancellation by calling our practice. This will allow time for another patient to be scheduled. Patients who have multiple, same-day cancellations or appointment no shows, may be dismissed from the practice at the provider's discretion.

Late Arrivals
Please call our practice as soon as you know you may be late. Depending on how late you arrive, you may be worked in, or asked to reschedule your appointment.

Phone Messages
Please allow 24 hours for a return call. Phone messages may not be returned until the end of the day once the last patient in the office has been seen. Phone calls are returned according to the urgency of a patient's medical situation. If you call us outside of clinic hours, your call will be sent to our after-hours line.

Referrals
Please allow up to five business days for scheduling referral appointments and outpatient procedures. Urgent appointments will be scheduled as soon as possible. This amount of time is required to verify insurance prior authorization requirements. If you need to change the appointment, you may contact the referral office to reschedule. Please check with your insurance company to see if prior approval is needed, as it is ultimately the patient's responsibility to know their insurance coverage.

Prescriptions
Please allow a 48-hour notification for prescription refills. To ensure the correct prescription is called in to the correct pharmacy, when leaving refill information, please specify your name and date of birth; the medication name, dosage, directions, quantity of the medication; and the pharmacy's name and phone number. The prescription refill process may be different for certain prescription types.

OFFICE POLICIES AND PROCEDURES
Continued

BAPTIST HEALTH®
MEDICAL GROUP

Test Results
The clinical staff will review results from labs or other tests when received by our practice. If anything needs to be addressed immediately, you will be notified by phone. If you have not heard anything after two weeks, please call our practice to check the status of your results.

Medical Records
You are entitled to one free copy of your medical records. Once a valid release is on file, please allow 30 days for the request to be processed. After the free copy, a charge of $1 per page applies. Requests by outside parties, such as an attorney, will be sent once a valid release and fee are received.

Documentation Requests
There may be a fee for documentation services. Such services include completing FMLA forms, life insurance forms, and letters written on behalf of the patient. Payment must be made before documentation is completed. The practice can provide an estimate of the fee based on your specific paperwork needs.

Required Items
Your referring doctor's office cannot send us your radiology images, you must bring the CD with you. Please bring the written report that is associated with your scans as well. You must bring your photo ID and any insurance cards. Copays are expected on the day of service or your appointment maybe rescheduled.

Failure to bring these items may result in rescheduling your appointment.

Patient Updates
Please be sure to notify us of any address and/or phone changes so that we can communicate your health status with you.

I have read and understand the policies and procedures listed above.

Print Name_____

Signature_____ Date_____

MyChart BAPTIST HEALTH®

Sign up for MyChart

Baptist Health's Patient Portal

To activate MyChart, you will need:

· Activation code
· Your date of birth
· Last four digits of your Social Security Number

You will likely receive an activation code in the "MyChart Signup" section of your After Visit Summary, which you receive after visiting a Baptist Health facility. You can also call the MyChart Help Desk at **1.844.764.7820** to get an activation code. The Help Desk will send a code via email or letter. Regardless of how you receive the activation code, the sign-up process is the same.

Once you have your activation code in hand, follow these steps to sign up:

1. Go to the MyChart website at MyChart.BaptistHealth.com.
2. Click the "Sign up Now" button.
3. Enter the activation code, the last four digits of your Social Security Number and your birthdate.
4. Click "Next."
5. Enter a user username, password and security question.
6. Click "Next."
7. Enter your email address for notifications (or select "no" if you do not wish to receive).
8. Click "Sign in."
9. Accept terms and conditions.
10. You're now signed up for MyChart!

If you don't have an activation code, follow these directions to obtain one:

1. Go to the MyChart website: MyChart.BaptistHealth.com
2. Click the "Sign up online" button in the right-hand column.
3. Fill out the form to request your activation code online.
4. Click "submit."
5. The MyChart Help Desk will contact you with an activation code via email or letter.