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 plan to arrive 30 minutes prior to your scheduled appointment time so that our staff can 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 previous primary care provider.

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

GENERAL INFORMATION

BAPTIST HEALTH®
MEDICAL GROUP

First Appointment
Please arrive to your first appointment 30 minutes early and bring your completed paperwork, list of current medications, as well as your photo ID and insurance cards.

If at any time you have questions or concerns, call the practice to speak to the staff. When leaving a message for a nurse, please include your full name (please spell your last name), date of birth, reason for calling, and a number where you can be reached. Our staff make every effort to return calls by the end of each business day.

Prescription Refills
At the time of your appointment, let the physician or nurse know of any refills you will need.

If you need refills outside of your appointment, please contact your local or specialty pharmacy. If you require a new prescription, please contact the practice. When leaving a voice message, please include your full name (spelling of last name), date of birth, the prescription that you require, and the following pharmacy information: pharmacy name, street location, city and phone number.

Insurance/Billing
You will be asked to provide us with a copy of your insurance coverage information at the first visit and at the start of each month thereafter. It is a requirement of your health insurance that copayments be collected at each visit, prior to seeing the physician.

We participate with most major insurance carriers and claims will be filed for you. For your convenience we accept cash, checks and major credit cards.

If you would like to speak with a financial counselor, please contact the practice. Our financial counselors can assist with copayment and deductible questions, as well as discuss payment options. They serve as a resource for our patients with questions regarding bills, cancer policies, and other forms of financial assistance. You DO NOT have to be insured to contact one of our counselors.

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
Do you have an Advanced Directive/Living Will? ❑Yes ❑No
Do you have a Power of Attorney? ❑Yes ❑No
Preferred Language: _____ Written Language: _____ Needs Interpreter? ❑Yes ❑No
Special Accommodations (Select as many that apply): ❑Hearing ❑Visual ❑Speech
❑Other _____
Student: ❑N/A ❑Full time ❑Part time School: _____
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: _____
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
Guarantor Employer: _____ Ph: _____
Address: _____

Insurance/Subscriber Information
Do you have medical coverage? ❑Yes ❑No If yes, are you the subscriber? ❑Yes ❑No
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 DEMOGRAPHIC INFORMATION FORM
Continued

BAPTIST HEALTH®
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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: _____

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

PATIENT INTAKE FORM

Full Name: _____ Today's Date: _____
Referring MD: _____
Address: _____
Phone:_____
Family MD: _____
Address: _____
Phone:_____
Surgeon: _____
Address: _____
Phone:_____
Medical Oncologist: _____
Address: _____
Phone:_____
Radiation Oncologist:_____
Address: _____
Phone:_____

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

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

ADULT MEDICAL HISTORY QUESTIONNAIRE

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Full Name: _____ Date of Birth: _____
Write in your own words the reason you are being seen: _____

Allergies: List any food/drug allergies you have or select N/A if you do not have any allergies.
1.
2.
3.
4.
❑N/A

Immunizations/Vaccinations: Check box and indicate date received. Please bring immunization record to your appointment.
❑Tetanus (Td/Tdap)/Date_____ ❑Flu/Date_____ ❑Pneumococcal (pneumonia)/ Date_____
❑Shingles/Date_____ ❑Rubella/Date_____ ❑Other_____

Patient Medical History: Check box if you have ever had the following health concerns:
❑Previous Cancer: Type/Kind:_____ When Diagnosed:_____
❑Previous Radiation Therapy: Where:_____ Duration:_____ Date_____
❑Previous Chemotherapy: Where:_____ Duration:_____ Date_____

❑Asthma/Emphysema
❑Angina
❑Arthritis
❑Bladder Problems
❑Blood Clotting Disorders
❑Blood Disorders/Anemia
❑Blood Transfusion
❑Bowel/Stomach Problems
❑Cataracts/Glaucoma
❑Chronic Bronchitis
❑Cirrhosis
❑Colitis
❑COP
❑Diabetes (sugar)
❑Deep Vein Thrombosis (DVT)
❑Diverticulitis
❑Epilepsy/Seizures
❑Gout
❑Fractures
❑Heart Attack
❑Heart Failure
❑Heart Murmur
❑Hepatitis/Liver Disease
❑High Blood Pressure
❑HIV/AIDS
❑Lupus or Scleroderma
❑Kidney Infection
❑Kidney Stones
❑Malignancy
❑Mental Illness/Anxiety/Depression
❑Pacemaker
❑Pancreatitis
❑Positive TB Test
❑Rheumatic Fever
❑Stroke
❑Thrombophlebitis
❑Thyroid Disease
❑Tuberculosis
❑Stroke
❑Thyroid Disease
❑Ulcers
❑Valve Replacement
❑VRE/MRSA/C. Diff
❑Other: _____

ADULT MEDICAL HISTORY QUESTIONNAIRE
Continued

BAPTIST HEALTH® MEDICAL GROUP

Family Medical History: If any blood relative has ever had any of the following, check box and indicate which relative(s):

❑Arthritis_____
❑Liver Disease_____
❑Abnormal Bleeding_____
❑Mental Illness_____
❑Cancer_____
❑Migraine Headaches_____
❑Diabetes_____
❑Obesity_____
❑Enlarged Spleen_____
❑Osteoporosis_____
❑Heart Attack_____
❑Spleen Removed_____
❑Heart Disease_____
❑Stroke_____
❑High Blood Pressure_____
❑Thyroid Disease_____
❑High Cholesterol_____
❑Tuberculosis_____
❑Kidney Disease_____
❑Other _____

Social History: Please check usage of the following:

Alcohol: ❑Never ❑Current – drinks per week _____ ❑Former – date stopped _____
Smoker: ❑Never ❑Current – type/start date _____ Packs per day _____
❑Former – date stopped _____
Smokeless tobacco/chewing tobacco: ❑Never ❑Current – daily usage_____
❑Former – date stopped _____
Vape/e-cigarettes: ❑Never ❑Current – daily usage_____ ❑Former – date stopped _____
Street drugs: ❑Type of drug _____ ❑Never ❑Current – daily usage_____
❑Former – date stopped _____

Personal and Family Cancer History:

	DIAGNOSIS		IF LIVING		IF DECEASED	
	Type/Site	Age at Diagnosis	Age	Health	Age of Death	Cause
Father						
Mother						
Brother(s)						
Sister(s)						
Children						
Spouse						
Other *(Paternal Maternal relation)*						

ADULT MEDICAL HISTORY QUESTIONNAIRE
Continued

BAPTIST HEALTH® MEDICAL GROUP

Personal Cancer History: Please check box for all that apply.
Previous biopsy with high-risk lesion? ❑Yes ❑No
Previous chest radiation treatment? ❑Yes ❑No
Multiple prior breast biopsies? ❑Yes ❑No
Are you of Ashkenazi Jewish descent? ❑Yes ❑No
Are you concerned about your personal and/or family history of cancer? ❑Yes ❑No
Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? ❑Yes ❑No

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

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

Colonoscopy:
Date of most recent:_____ Next scheduled:_____
CT:
Date of most recent:_____ Next scheduled:_____
Bone Density Scan:
Date of most recent:_____ Next scheduled:_____

Female patients only:
Age of 1st Menses: _____
Bleeding Between Periods? ❑Yes ❑No
Painful Period? ❑Yes ❑No
Age of 1st Live Birth: _____
Number of Deliveries: _____
Date of Last PAP Smear:_____
Date of Last Mammogram:_____
Last Menstrual Period: _____
OR Age at Menopause: _____
Length of Period: _____
Period:❑Normal ❑Heavy ❑Light
Next PAP Smear due: _____
Next Mammogram due:_____
Number of Direct Relatives with Breast Cancer: _____
Number of Previous Breast Biopsies: Left: ____ Right:_____
Any biopsy showing "atypical ductal hyperplasia?" ❑Yes ❑No
Taking Birth Control Pills? ❑Yes ❑No IUD? ❑Yes ❑No Hormones? ❑Yes ❑No

ADULT MEDICAL HISTORY QUESTIONNAIRE
Continued

BAPTIST HEALTH® MEDICAL GROUP

Personal Activity Status: Please check the one that applies.
❑Normal, with no limitations
❑Not my normal self, but able to be up and about with fairly normal activities
❑Not feeling up to most things, but in bed less than half the day
❑Able to do little activity, and spend most the day in bed or chair
❑Rarely out of bed, pretty much bedridden

Nutrition Status:
Are you currently taking nutrition drinks? ❑Yes ❑No If yes, please specify_____
Do you currently have a feeding tube? ❑No ❑Stomach ❑Intestine
Would you like to request a dietitian consultant? ❑Yes ❑No If yes, please specify_____

Symptoms: Please check any current symptoms or complaints and write in anything not listed.

General/Overall
❑Fatigue
❑Hot flashes
❑Fever
❑Chills
❑Pain
❑Other:_____

Mouth/Throat
❑Bleeding
❑Sores
❑Thrush
❑Hoarseness
❑Sore throat
❑Difficulty swallowing
❑Dry mouth
❑Altered taste
❑Other:_____

Skeletal
❑Bone/Joint pain
❑Joint hemorrhages
❑Cramps
❑Limping
❑Other:_____

Breast
❑Lumps
❑Pain
❑Discharge
❑Swelling
❑Other:_____

Skin
❑Rash
❑Itching
❑Change in appearance of moles
❑Ulcers
❑Other:_____

Eyes
❑Blindness
❑Itchy or Dry
❑Blurred vision
❑Double vision
❑Other:_____

Cardiovascular
❑Chest pain
❑Palpitations
❑Other:_____

Pulmonary
❑Cough (dry or productive)
❑Wheezing
❑Blood in sputum
❑Shortness of breath
❑Other:_____

Neurologic
❑Headache
❑Seizures
❑Dizziness
❑Weakness
❑Numbness/Tingling
❑Changes in gait
❑Fainting
❑Other:_____

Immunologic
❑Frequent infections
❑Enlarged glands
❑Other:_____

Ears
❑Bleeding
❑Draining
❑Ringing in ears
❑Hearing loss
❑Earache
❑Vertigo
❑Other:_____

Gastrointestinal
❑Poor or no appetite
❑Nausea
❑Vomiting
❑Heartburn
❑Abdominal pain
❑Vomiting blood
❑Chronic constipation
❑Diarrhea
❑Change in color /consistency of stool
❑Blood in stool
❑Weight loss
❑Weight gain

Psychiatric
❑Depression
❑Anxiety
❑Insomnia
❑Confusion
❑Memory loss
❑Emotional problems
❑Other:_____

Hematologic
❑Easy bruising
❑Tooth extraction/Gum bleeding
❑Bleeding
❑Anemia
❑Other:_____

Nose
❑Bleeding
❑Draining
❑Sinus problems
❑Other:_____

Genitourinary
❑Pain urinating
❑Blood in urine
❑Increased frequency of urination
❑Hesitancy when starting to urinate
❑Increased urgency to urinate
❑Change in urine stream
❑Leakage of urine
❑Flank pain
❑Number of times urinating at night_____
❑Impotence
❑Potency (#times week)____
❑Full erections ❑Yes ❑No
❑Vaginal discharge
❑Pelvic pain with intercourse
❑Abnormal vaginal bleeding
❑Other:_____

Assistive Devices
❑Dentures
❑Partials
❑Corrective lenses
❑Hearing aids
❑Pacemaker
❑Cane/Walker
❑Home oxygen
❑Other:_____

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®
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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.

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.

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.