BAPTIST HEALTH®
MEDICAL GROUP

WELCOME TO

ADDRESS	
PHONE	
FAX	
HOURS	
AFTER-HOURS	

Dear _____,

Thank you for trusting Baptist Health Medical Group with your care. Enclosed in this New Patient Packet are the following:

- Patient forms to be completed prior to visit
- Policies and procedures
- Controlled substance statement

We want to do our best to ensure the timeliness of your visit. In order to do so, we ask that you please arrive 15 minutes prior to your scheduled appointment time. 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 (co-pay, co-insurance, pre-pay)
- ✔ Medical records from your previous primary care provider
- ✔ Guardianship form for foster children

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

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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/Alaska ❑Native Hawaiian/Pacific Islander
Preferred Language: _____ Written Language: _____ Needs Interpreter? ❑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: _____
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
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: _____
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: _____

ADULT MEDICAL HISTORY QUESTIONNAIRE

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

Operations: List any surgical operations you have had or select N/A if you have not had any surgical operations.
1. _____ Date_____ 2. _____ Date_____
3. _____ Date_____ 4. _____ Date_____
❑ N/A

Allergies: List any drugs you are allergic to or select N/A if you have 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 vaccine/Date_____ ❑Other_____

Patient Medical History: Check box if you have ever had the following health concerns:
❑Arthritis (Joint Pain / Swelling) ❑Diabetes ❑Kidney / Bladder ❑Sleep Apnea
❑Blood Disorder ❑Epilepsy / Seizures ❑Liver ❑Stomach / Bowel
❑Bone Disorder / Fractures ❑Headaches ❑Memory ❑Stroke
❑Breathing / Lung ❑Heart Burn / Indigestion ❑Prostate Problems (M) ❑Thyroid Disease
❑Cancer Type: _____ ❑Heart Problem / Chest Pain ❑Menstrual Problems (F) ❑Vision
❑Circulation ❑High Blood Pressure ❑Skin / Hair
❑Depression / Anxiety ❑High Cholesterol ❑Others (List): _____

Family Medical History: If any blood relative has ever had any of the following, check box and indicate which relative(s):
❑Arthritis_____ ❑Liver Disease_____ ❑Bleeding Tendency_____
❑Mental Illness_____ ❑Cancer_____ ❑Migraine Headaches_____
❑Diabetes_____ ❑Obesity_____ ❑Heart Attack_____
❑Osteoporosis_____ ❑High Blood Pressure_____ ❑Stroke_____
❑High Cholesterol_____ ❑Thyroid Disease_____
❑Kidney Disease_____ ❑Tuberculosis_____

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 _____

PEDIATRIC MEDICAL HISTORY QUESTIONNAIRE

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

Operations: List any surgical operations you have had or select N/A if you have not had any surgical operations.
1. _____ Date_____ 2. _____ Date_____
3. _____ Date_____ 4. _____ Date_____
❑ N/A

Allergies: List any drugs you are allergic to or select N/A if you have 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. ❑Flu/Date_____

Patient Medical History: Check box if you have ever had the following health concerns:
❑ADD ❑Cancer Type_____ ❑GERD / Heartburn ❑Liver Disease ❑Asthma
❑Bowel Issues / Ulcer ❑Hearing Loss ❑Migraine Headaches ❑Allergies ❑Constipation – chronic
❑Irregular Heartbeat ❑Ovarian Cysts ❑Anemia ❑Depression ❑Heart Murmur ❑Positive TB Test
❑Anxiety ❑Diabetes ❑High Blood Pressure ❑Rheumatic Fever ❑Bipolar Disorder
❑Diarrhea – chronic ❑Kidney Disease ❑Thyroid Disease ❑Blood in Urine ❑Epilepsy / Seizures
❑Kidney Infection / UTI ❑Blood Transfusions ❑Fractures ❑Kidney Stones

Family Medical History: If any blood relative has ever had any of the following, check box and indicate which relative(s):
❑ADD/ADHD _____ ❑High Blood Pressure_____ ❑Anemia_____
❑High Cholesterol_____ ❑Arthritis_____ ❑Kidney Disease_____
❑Asthma_____ ❑Liver Disease_____ ❑Bleeding Tendency_____
❑Mental Illness_____ ❑Cancer (please specify)_____
❑Migraine Headaches_____ ❑Colon Polyps _____ ❑Obesity_____
❑Diabetes_____ ❑Osteoporosis_____ ❑Heart Attack_____
❑Stroke_____ ❑Thyroid Disease_____ ❑Other(s)_____

Social History: Please check usage of the following:
Firearms in the home? ❑Yes ❑No Current grade in school or daycare:_____
Hours of screen time daily (iPad, tablets, TV, video games, etc.)? _____

Pediatric:
Exposed to second hand smoke? ❑Yes ❑No
Seatbelt usage (if older than age 8)? ❑Yes ❑No Car seat (if younger than age 4)? ❑Yes ❑No
Back seat? ❑Yes ❑No Rear facing? ❑Yes ❑No Front facing? ❑Yes ❑No
Booster seat? ❑Yes ❑No

Adolescent:
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 _____
Do you have a current history of blood transfusions? ❑Yes ❑No

OFFICE POLICIES AND PROCEDURES

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MyChart
Patients who sign up for MyChart will have free access to their Baptist Health medical records and test results. 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
Co-payments (co-pays) are required the day of service. If your co-pay 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 co-pay 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 operating hours, your call will be sent to our after-hours line.

Referrals
Please allow 4-5 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.

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Test Results
The clinical staff reviews results from labs or other tests when received by our practice. If anything needs to be addressed immediately, you will be notified by phone. Alternatively, the practice may communicate test results via MyChart for active users. Otherwise, you will be notified of results by mail within 2 weeks. If you have not heard anything after 2 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 the 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.

CONTROLLED SUBSTANCE STATEMENT

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We are honored you have chosen Baptist Health for your primary care needs. We know you have many options for your health care and are humbled that you have chosen us as your provider. We will accomplish many things during your first visit – one will be to obtain a list of your current medications. Below is a statement to help you understand our view of the continuation of controlled substances.

If you have been prescribed controlled substances by previous or current medical providers, your Baptist Health provider will carefully review your needs and will evaluate your current medications. Your provider may discuss with you different options for continued treatment of your underlying medical conditions. If your provider determines that continuation of these medications are not in the best interest of your medical care, your provider may discuss with you a safe method to stop these medications and make recommendations for any medicine that should replace them.

Thank you again for choosing Baptist Health Medical Group for your care.