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 and/or your specialist.

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.

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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: _____
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: _____

Patient name: _____

Date of birth: _____

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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: _____

Patient name: _____

Date of birth: _____

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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 /Vitamins	Dosage (If known)	How many Daily?	Name of Drug/Medicine /Vitamins	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: _____

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History of Present Illness

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

When did your symptoms begin? _____

Are your symptoms getting worse? _____

Does anything trigger your symptoms? _____

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? _____

If you have seen any other doctor's office for this problem, please list them below. _____

_____

If you have had any test done for this problem, please list them below. _____

_____

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

_____

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

❑Allergies - Environmental
❑Amyotrophic Lateral Sclerosis
❑Aneurysm
❑Angina
❑Anxiety/Panic Attacks
❑Arthritis
❑Asthma/Emphysema
❑Atrial Fibrillation
❑Bell's Palsy
❑Bladder Problems
❑Bleeding Disorder
❑Blood Clotting Disorders
❑Blood Disorders/Anemia
❑Blood Transfusion (reaction: ❑Yes ❑No)
❑Brain Tumor
❑Bowel/Stomach Problems
❑Cataracts/Glaucoma
❑Cancer/Type: _____
❑Carotid Disease
❑Carpal Tunnel
❑Cervical Spine Disease
❑Changes in gait
❑Chronic Bronchitis
❑Cirrhosis
❑Colitis
❑Congestive Heart Failure
❑COPD
❑Coronary Artery Disease
❑Deep Vein Thrombosis (DVT)
❑Dementia
❑Depression
❑Developmental Delay
❑Diabetic Neuropathy
❑Diabetes (Sugar)
❑Diverticulitis
❑Dizziness
❑Epilepsy/Seizures
❑Exposure to Toxins
❑Fainting
❑Fibromyalgia
❑Gall Stones
❑Gout
❑Fractures
❑Headache - Cluster
❑Headache - Migraine
❑Headache - Tension
❑Hearing Loss
❑Heart Attack
❑Heart Failure
❑Heart Murmur
❑Kidney Infections
❑Kidney Stones
❑Hepatitis/Liver Disease
❑High Blood Pressure
❑HIV/AIDS
❑Hyperlipidemia
❑Hypertension
❑Intracranial Bleed
❑Liver Disease
❑Lupus or Scleroderma
❑Mental Illness/Anxiety
❑Memory Loss
❑Movement Disorder
❑Multiple Sclerosis
❑Neuropathy
❑Neuromuscular Disease
❑Numbness/Tingling
❑Peripheral Vascular Disease
❑Pacemaker
❑Pancreatitis
❑Polio
❑Positive TB Test
❑Rheumatic Fever
❑Seizures
❑Shingles
❑Sleep Apnea
❑Stroke
❑Syncope
❑Thyroid Disease
❑TIA
❑Thrombophlebitis
❑Thyroid Disease
❑Trigeminal Neuralgia
❑Tuberculosis
❑Ulcers
❑Valve Replacements
❑VRE/MRSA/C-Diff
❑Walking Difficulty
❑Weakness
❑Other: _____

Patient name: _____

Date of birth: _____

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Social History

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? _____
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: ❑Never ❑Type of drug _____
❑Current – daily usage_____ ❑Former – date stopped _____

Do you live alone or with family? _____

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

Indicate Family Member
Arthritis
Aneurysm
Ataxia
Alcoholism
Alzheimer's Disease
Brain Tumor
Chorea
Cancer/Type:
Diabetes
Dementia
Epilepsy
Heart Disease
High Blood Pressure
High Cholesterol
Kidney Disease

Indicate Family Member
Liver Disease
Mental Illness/Suicide
Migraine Headaches
Multiple Sclerosis
Neurofibromatosis
Neuromuscular Disease
Neuropathy
Obesity
Osteoporosis
Other Neurological Disease
Parkinson's Disease
Suicide
Stroke
Thyroid Disease
Other:

Patient name: _____

Date of birth: _____

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

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

Review of systems

Check the box if you are experiencing any of the following.

Constitution
- ❑Activity change
- ❑Appetite change
- ❑Chills
- ❑Diaphoresis
- ❑Fatigue
- ❑Fever
- ❑Unexpected weight change

HENT
- ❑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-headed
- ❑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

OFFICE POLICIES AND PROCEDURES

BAPTIST HEALTH®
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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.