Patient name: _____
Date of birth: _____

BAPTIST HEALTH®
MEDICAL GROUP

WELCOME TO BAPTIST HEALTH MEDICAL GROUP

ADDRESS:	
PHONE:	
FAX:	
HOURS:	
AFTER HOURS:	

Dear _____,

Thank you for trusting Baptist Health Medical Group with your care. Our team of physicians and staff is committed to providing you with 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 visit.
- Policies and procedures.

We want to do our best to ensure the timeliness of your visit. To do so, we ask that you bring any applicable items listed below.

- ✔ Attached forms completed in full.
- ✔ Photo ID.
- ✔ Insurance cards.
- ✔ List of current medications and supplements.
- ✔ Any payment you may have (copayment, coinsurance, prepay).
- ✔ Medical records from your previous primary care provider and/or specialist, including office notes, imaging reports, discs, and any other relevant diagnostic testing.
- ✔ Advance care planning documents (e.g., power of attorney forms, living will, healthcare surrogate).

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 Baptist Health Medical Group healthcare team

Patient name: _____
Date of birth: _____

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PATIENT DEMOGRAPHIC INFORMATION FORM

Please print legibly.

Date: _____

Full name: _____ Date of birth: _____ SSN: _____

Age: _____ Sex: _____ Address: _____

City: _____ State: _____ ZIP code: _____

Home phone: _____ Work phone: _____ Cell phone: _____

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 advance directive/living will? ❑Yes ❑No

Do you have a power of attorney? ❑Yes ❑No

Do you have other advance care planning considerations/documents? _____

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: _____ Employer phone: _____

Employer address: _____

Primary physician (first and last name): _____

Primary physician phone: _____

Referring physician (first and last name): _____

Emergency contact: _____ Relationship: _____

Emergency contact phone: _____

Guarantor information

Information for 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 phone: _____ Work phone: _____ Cell phone: _____

Employment status: ❑Full time ❑Part time ❑Not employed ❑Military duty ❑Self-employed
❑Disabled ❑Student full time ❑Student part time ❑Retired

Guarantor employer: _____ Phone: _____

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: _____
Employer phone: _____ Employer 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: _____
Employer phone: _____ Employer address: _____

Preferred pharmacy (local)

Please specify preferred local pharmacy.
Pharmacy name:_____ Phone:_____
Address: _____
City: _____ State: _____ ZIP code: _____

Preferred pharmacy (mail order)

Please specify preferred mail-order pharmacy.
Pharmacy name:_____ Phone:_____
Address: _____
City: _____ State: _____ ZIP code: _____

Patient name: _____
Date of birth: _____

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Current medications

Please list all prescriptions and over-the-counter medications, herbal drugs and vitamins (include dose and frequency). If additional space is required, please continue to list medications on a separate page.

Name of drug/medicine /vitamin	Dosage (if known)	How many daily?	Name of drug/medicine /vitamin	Dosage (if known)	How many daily?
1.			11.		
2.			12.		
3.			13.		
4.			14.		
5.			15.		
6.			16.		
7.			17.		
8.			18.		
9.			19.		
10.			20.		

Food and/or medication allergies

Please list all allergies below.

Name of drug/medicine/other allergen (i.e., peanuts)	Reaction type (i.e., hives, rash, sneezing, anaphylaxis)	Severity (i.e., low, medium, high)
1. Latex: ❑Yes ❑No		
2.		
3.		
4.		
5.		
6.		

Immunization/vaccination

Check to indicate and list date received.

❑Influenza _____
❑Pneumococcal _____
❑Shingles _____
❑Tetanus _____
❑Rubella _____
❑COVID-19 _____

Patient name: _____
Date of birth: _____

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Past medical history

Check the box if you have ever had the following.

❑Acid reflux
❑Anemia
❑Angina
❑Arthritis
❑Asthma
❑Bipolar disorder
❑Blood clots
❑Blood transfusion (Reaction: ❑Yes ❑No)
❑Cancer: _____
❑Chronic bronchitis
❑Cirrhosis
❑Colitis
❑Colon polyps
❑Depression
❑Diabetes
❑Diverticulitis
❑Emphysema/COPD
❑Epilepsy/seizures
❑Fibromyalgia
❑Fractures
❑Frequent UTIs
❑Gall stones
❑Glaucoma
❑Gout
❑Heart attack
❑Heart disease
❑Heart failure
❑Heart murmur
❑Hepatitis
❑High cholesterol
❑Hypertension
❑Kidney infection
❑Kidney stones
❑Migraine headaches
❑Osteoporosis/low bone density
❑Ovarian cysts
❑Pacemaker/ defibrillator
❑Pancreatitis
❑Poor blood clotting
❑Positive TB test
❑Rheumatic fever
❑Seizures
❑Stroke
❑Thyroid disease
❑Tuberculosis
❑Ulcers
❑Other (list below):
_____
_____
_____
_____
_____
_____
_____

Social history

Do you now or have you ever used any tobacco products (tobacco or snuff/chew)?
❑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, which: ❑Amphetamines ❑Heroin ❑Cocaine ❑Marijuana ❑Barbiturates ❑Other: _____
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: _____

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Family history

List any significant illness in your immediate family members (father, mother, brother(s), sister(s)).

Indicate family member
Arthritis, gout
Asthma, hay fever
Cancer
Chemical dependency
Diabetes
Heart attack

Indicate family member
Heart disease
High blood pressure
High cholesterol
Kidney disease
Stroke
Other:

Family relationship	Age	Disease	If deceased, cause of death
Father			
Mother			
Brother(s)			
Sister(s)			
Children			
Spouse			
Other (paternal/ maternal relation)			

Patient name: _____
Date of birth: _____

BAPTIST HEALTH®
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Surgical history

List all operations with approximate dates or age.

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

Testing history

Type of test	Testing location
Cardiac catheterization: ❑Yes ❑No	
Stress test: ❑Yes ❑No	
Echocardiogram: ❑Yes ❑No	
Recent EKG: ❑Yes ❑No	
Labs within the last 12 months: ❑Yes ❑No	

Diagnostic imaging history

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

Patient name: _____
Date of birth: _____

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Review of systems

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

Constitution
- ❑Activity change
- ❑Appetite change
- ❑Chills
- ❑Fever
- ❑Sweating
- ❑Tiredness
- ❑Unexpected weight change

HENT
- ❑Congestion
- ❑Dental problem
- ❑Drooling
- ❑Ear discharge
- ❑Ear pain
- ❑Facial swelling
- ❑Hearing loss
- ❑Mouth sores
- ❑Nosebleeds
- ❑Postnasal drip
- ❑Ringing in ears
- ❑Runny nose
- ❑Sinus pressure
- ❑Sneezing
- ❑Sore throat
- ❑Trouble swallowing
- ❑Voice change

Eyes
- ❑Discharge
- ❑Itching
- ❑Light sensitivity
- ❑Pain
- ❑Redness
- ❑Visual disturbance

Respiratory
- ❑Chest tightness
- ❑Choking
- ❑Cough
- ❑Pauses in breath
- ❑Shortness of breath
- ❑Stridor
- ❑Wheezing

Cardiovascular
- ❑Chest pain
- ❑Leg swelling
- ❑Palpitations

Gastrointestinal
- ❑Abdominal pain
- ❑Anal bleeding
- ❑Blood in stool
- ❑Constipation
- ❑Diarrhea
- ❑Nausea alone
- ❑Nausea and vomiting
- ❑Rectal pain
- ❑Reflux/heartburn
- ❑Vomiting
- ❑Vomiting of blood
- ❑Weight loss

Endocrine
- ❑Cold intolerance
- ❑Excessive hunger
- ❑Excessive thirst
- ❑Excessive urination
- ❑Heat intolerance

Genitourinary
- ❑Blood in urine
- ❑Difficulty urinating
- ❑Flank pain
- ❑Frequency
- ❑Genital sore
- ❑Involuntary urination/ bladder leakage
- ❑Menstrual problem
- ❑Pain with sexual intercourse
- ❑Pain with urination
- ❑Pelvic pain
- ❑Urgent urination
- ❑Urine decreased
- ❑Vaginal bleeding
- ❑Vaginal discharge
- ❑Vaginal pain

Musculoskeletal
- ❑Back pain
- ❑Joint pain
- ❑Joint swelling
- ❑Muscle aches
- ❑Neck pain
- ❑Neck stiffness

Skin
- ❑Color change
- ❑Paleness
- ❑Rash
- ❑Wound

Allergic/immunologic
- ❑Environmental allergies
- ❑Food allergies
- ❑Immunocompromised

Neurological
- ❑Dizziness
- ❑Facial asymmetry
- ❑Headaches
- ❑Light-headed
- ❑Numbness
- ❑Passing out
- ❑Seizures
- ❑Speech difficulty
- ❑Tremors
- ❑Weakness

Hematologic
- ❑Bruises/bleeds easily
- ❑Swollen glands

Psychiatric
- ❑Agitation
- ❑Behavior problem
- ❑Confusion
- ❑Decreased concentration
- ❑Hallucinations
- ❑Hyperactive
- ❑Nervous/anxious
- ❑Sadness
- ❑Self-injury
- ❑Sleep disturbance
- ❑Suicidal ideas and/or thoughts of self-harm

OFFICE POLICIES AND PROCEDURES

BAPTIST HEALTH®
MEDICAL GROUP

MyChart
Patients who sign up for MyChart will have free access to their Baptist Health Medical Group 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 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 operating 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 into the correct pharmacy, when leaving refill information please specify your name and date of birth; the medication name, dosage, directions, and 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 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. 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 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.

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

Patient updates
Please be sure to keep us updated 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 **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" button.
3. Enter the activation code, the last four digits of your Social Security number and your birthdate.
4. Click "Next."
5. Enter a 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 without Activation Code" 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.