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 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 (copayment, coinsurance, prepay).
- ✔ Medical records from your previous primary care provider and/or your specialist.
- ✔ Important documents, including CD with images, such as MRIs, X-rays and CT scans, as well as any written reports and other relevant diagnostic testing you have done.

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: _____

BAPTIST HEALTH®
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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: ❑Single ❑Married ❑Divorced ❑Widowed Religion: _____

Ethnicity: ❑Hispanic/Latino ❑Non-Hispanic/Latino

Are you a veteran? ❑Yes ❑No

Race: ❑White ❑Black/African American ❑Asian ❑Native American/Alaska Native
❑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 Is it on file with Baptist Health? ❑Yes ❑No

Special accommodations (Select as many that apply.): ❑Hearing ❑Visual ❑Speech
❑Other _____

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

Employer: _____ Phone: _____

Employer address: _____

Primary physician (first and last name): _____ Phone: _____

Referring physician (first and last name): _____

Emergency contact: _____ Relationship: _____

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 Year 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: _____
Phone: _____ 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: _____
Phone: _____ Address: _____

Preferred pharmacy: ❑Retail ❑Mail order
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).

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.		

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.		
7.		
8.		
9.		

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
❑AIDS/HIV
❑Anemia
❑Anesthesia complications
❑Anxiety
❑Arthritis
❑Asthma
❑Atrial fibrillation
❑Back problems
❑Bladder infections
❑Bleeding
❑Bleeding tendency
❑Blood clots
❑Blood disease
❑Blood transfusion (Reaction: ❑Yes ❑No)
❑Bronchitis
❑C. diff
❑Coronary artery disease
❑Cancer: _____
❑Claustrophobia
❑Convulsions
❑COPD
❑Diabetes (sugar)
❑Diverticulitis
❑Diverticulosis
❑Emphysema
❑Epilepsy
❑Gallstones
❑GERD
❑Glaucoma
❑Gout
❑Headache - migraine
❑Hearing loss
❑Heart attack
❑Heart disease
❑Heart failure
❑Hernia
❑Hepatitis
❑High blood pressure
❑High cholesterol
❑Kidney disease
❑Kidney stones
❑Liver disease
❑Lupus
❑Osteoporosis
❑Mental disorder
❑MRSA
❑Parathyroid disease
❑Pneumonia
❑Peripheral vascular disease
❑Polio
❑Recent infections
❑Rheumatoid arthritis
❑Rheumatic fever
❑Seizures
❑Stroke
❑Thyroid disease
❑Ulcers

Preventive medicine

How much do you weigh?_____ What is your height?_____
Date of last mammogram: _____
Date of last colonoscopy: _____ Where? _____ History of polyps? ❑Yes ❑No

Social history

Do you now, or have you ever used any tobacco products (tobacco or snuff, chew, e-cigarette or vape pen)?
❑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 drink caffeine? ❑Yes ❑No If yes, how much per day? _____
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? _____

Patient name: _____
Date of birth: _____

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Reason for today's visit and current symptoms:

_____

_____

_____

Family history

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

Indicate family member
Arthritis, gout: ❑Father ❑Mother ❑Brother ❑Sister ❑Other
Asthma, hay fever: ❑Father ❑Mother ❑Brother ❑Sister ❑Other
Cancer: ❑Father/Type:_____ ❑Mother/Type:_____ ❑Brother/Type:_____ ❑Sister/Type:_____ ❑Other/Type:_____
Chemical dependency: ❑Father ❑Mother ❑Brother ❑Sister ❑Other
Diabetes: ❑Father ❑Mother ❑Brother ❑Sister ❑Other
Heart disease: ❑Father ❑Mother ❑Brother ❑Sister ❑Other
High blood pressure: ❑Father ❑Mother ❑Brother ❑Sister ❑Other
Kidney disease: ❑Father ❑Mother ❑Brother ❑Sister ❑Other
Tuberculosis: ❑Father ❑Mother ❑Brother ❑Sister ❑Other
Other _____: ❑Father ❑Mother ❑Brother ❑Sister ❑Other

Patient name: _____
Date of birth: _____

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Surgical/testing/imaging history.
List all operations with approximate dates or age.

Common surgeries include:

- Appendectomy
- Gallbladder
- Colonoscopy
- EGD
- Hysterectomy or ovary removal
- Hernia (abdominal, groin, hiatal)
- Back, knee, hip
- Gastrointestinal
- Breast biopsy
- Breast surgery
- Heart
- Defibrillator
- Pacemaker
- Powerport®/Mediport®
- Vascular/cardiac stent
- Eye
- Dialysis catheter
- Thyroid/parathyroid

Common tests include:

- Cardiac catheterization
- Stress test
- Echocardiogram
- EKG

Common imaging tests include:

- MRI
- CT
- Kidney, ureter, bladder X-ray
- Ultrasound

Type of surgery	Patient's age	Approximate date of surgery	Location	Doctor
1.				
2.				
3.				
4.				

Type of test	Patient's age	Approximate date of test	Location	Doctor
1.				
2.				
3.				
4.				

Type of imaging test	Patient's age	Approximate date of imaging test	Location	Doctor
1.				
2.				
3.				
4.				

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
- ❑Fatigue
- ❑Fever
- ❑Unexpected weight change
- ❑Sweating

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

Skin
- ❑Color change
- ❑Pallor
- ❑Rash
- ❑Wound

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

Breast
- ❑Breast pain
- ❑Breast lump
- ❑Breast skin changes
- ❑Nipple discharge
- ❑Nipple inversion

Respiratory
- ❑Apnea
- ❑Chest tightness
- ❑Choking
- ❑Cough
- ❑Dizziness with exertion
- ❑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

Eyes
- ❑Discharge
- ❑Itching
- ❑Pain
- ❑Redness
- ❑Yellowness
- ❑Light sensitivity

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

Genitourinary
- ❑Difficulty urinating
- ❑Dyspareunia
- ❑Dysuria
- ❑Enuresis
- ❑Flank pain
- ❑Frequent urination
- ❑Genital sore
- ❑Hematuria
- ❑Menstrual problem
- ❑Pelvic pain
- ❑Urgent need to urinate
- ❑Decreased urine output
- ❑Vaginal bleeding
- ❑Vaginal discharge
- ❑Vaginal pain

Musculoskeletal
- ❑Arthralgias
- ❑Back pain
- ❑Gait problem
- ❑Joint swelling
- ❑Limited range of motion of the: _____
- ❑Myalgias
- ❑Neck pain
- ❑Neck stiffness

Neurological
- ❑Balance problem
- ❑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
- ❑Depression
- ❑Dysphoric mood
- ❑Hallucinations
- ❑Hyperactive
- ❑Nervous/anxious
- ❑Self-injury
- ❑Sleep disturbance
- ❑Suicidal thoughts

Patient name: _____
Date of birth: _____

BAPTIST HEALTH®
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WRITTEN PRESCRIPTION RELEASE FORM

Dear Patient,

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 prescription medication on your behalf. A valid photo ID is required to pick up a prescription.

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 Baptist Health Medical Group.

_____	_____
Authorized individual	Relationship to patient
_____	_____
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): _____
Date of birth: _____

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 Group 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 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 in to 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®
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.

Baptist Health releases your results in MyChart as soon as they are available. However, this means that you may see results even before your healthcare provider has reviewed them.

You may choose to view your results in MyChart, or you may prefer to wait until your provider's office contacts you. Depending on your results, a detailed conversation with your provider or their office may not be needed.

If you have not heard within three to four days, you may want to view your results on MyChart or contact your provider's office before viewing the results on your own.

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.