Patient name: _____
Date of birth: _____

BAPTIST HEALTH®
MEDICAL GROUP

WELCOME TO BAPTIST HEALTH MEDICAL GROUP ORTHOPEDICS

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.

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 (copayment, coinsurance, prepay).
- ✔ Medical records from your previous primary care provider and/or your specialist.
- ✔ Guardianship form for foster children.
- ✔ Important documents include: CD with images such as MRIs, X-rays, CT scans as well as any written reports and other relevant diagnostic testing you had 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: _____

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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: _____

Are you a veteran? ❑Yes ❑No

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 _____

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

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: _____

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 /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.		

Medication allergies	Reaction
1.	
2.	
3.	
4.	
5.	

Food and/or other allergies

List all that apply.

1. Latex: ❑Yes ❑No

2. _____

3. _____

4. _____

5. _____

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? _____

Onset: ❑No trauma ❑Fall ❑Dizziness/fainting ❑Twisting injury ❑Direct blow ❑Other _____

Which side? ❑Right ❑Left ❑Both Are you right- or left-handed? ❑Right ❑Left

Which body part(s)? ❑Hip ❑Knee ❑Ankle ❑Foot ❑Wrist ❑Hand ❑Elbow ❑Shoulder ❑Back ❑Other: _____

When did your symptoms begin? _____

Tell us about your pain. Is it: ❑Mild ❑Moderate ❑Severe

Pain scale: zero is no pain; 10 is the worst pain possible.

❑0 ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10

How would you describe your pain? ❑Crushing ❑Throbbing ❑Stabbing ❑Shooting ❑Grinding ❑Aching ❑Dull ❑Burning

Have you noticed any of the following? ❑Redness ❑Swelling ❑Bruising ❑Stiffness ❑Giving way ❑Clicking/popping/snapping

Do any of these things make it worse? ❑Standing ❑Sitting ❑Working ❑Driving ❑Walking ❑Running ❑Climbing stairs ❑Leisure

Do any of these things make it feel better? ❑Ice ❑Heat ❑Rest ❑Medication

❑Steroid/visco injections Date: _____ Body part: _____

Is there anything else you have found that is associated with your symptoms? _____

Which treatments have you tried? ❑Bracing ❑Cane/walker ❑Physical therapy ❑Weight loss

❑Oral steroids ❑Pain medication: _____ ❑Other medications: _____

❑Non-steroidal anti-inflammatory (Advil, Aleve, Ibuprofen, Celebrex, Naprosyn, Mobic, etc.)

How long? _____

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

Have you had previous surgery on this body part? Type:_____

Date:_____ Doctor:_____

Prior studies ❑X-ray ❑CT scan ❑MRI ❑Bone scan ❑Lab ❑Nerve testing ❑Other: _____

Where did you have the prior studies? _____

Are you pregnant or is there a chance you might be? ❑Yes ❑No ❑N/A

Are you being seen because of workers' compensation or a motor vehicle accident? ❑Yes ❑No

❑Workers' compensation ❑Motor vehicle accident

Occupation:_____ Last day worked: _____

Work status: ❑Retired ❑Full duty ❑Restrictions

Current physical therapy: ❑Yes ❑No If yes, where? _____

Do you have any of the following?

❑Fevers ❑Chills ❑Night sweats ❑History of blood clots

Patient name: _____
Date of birth: _____

BAPTIST HEALTH®
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Past medical history

Check the box if you have ever had the following.

❑AIDS/HIV
❑Anemia
❑Arthritis
❑Asthma
❑Back problems
❑Bladder infections
❑Bleeding
❑Bleeding tendency
❑Blood disease
❑Blood transfusion
(Reaction: ❑Yes ❑No)
❑Bronchitis
❑Bunions
❑Cancer: _____
❑Callus
❑Claustrophobic
❑Convulsions
❑Diabetes (sugar)
❑Emphysema
❑Epilepsy
❑Fallen arches
❑Gout
❑Headache - migraine
❑Hearing loss
❑Heart attack
❑Heart disease
❑Heart failure
❑Hernia
❑Hepatitis
❑High blood pressure
❑Hypertension
❑Ingrown toenails
❑Kidney disease
❑Osteoporosis
❑Plantar fasciitis
❑Plantar warts
❑Pneumonia
❑Polio
❑Recent infections
❑Rheumatic fever
❑Seizures
❑Stroke
❑Thyroid disease
❑Other:_____

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

Family history

List any significant illness in your immediate family members.

Indicate family member	Indicate family member
Arthritis, gout	Heart disease
Asthma, hay fever	High blood pressure
Cancer	Kidney disease
Chemical dependency	Tuberculosis
Diabetes	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
❑Frequent urination
❑Genital sore
❑Hematuria
❑Menstrual problem
❑Pelvic pain
❑Urgent need to urinate
❑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
❑Blood clots

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®
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: 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 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, 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 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.

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.