BMG | BAPTIST MEDICAL GROUP

PATIENT REGISTRATION

MRN_____

Date_____ Referring Physician _____ Primary Care Physician _____

Patient Last Name_____ First Name _____ Middle Initial_____ Suffix _____(Jr/Sr/II etc.)

☐ Male ☐ Female Date of Birth _____/_____/_____ Soc. Sec. #_____

Address _____ City_____ State_____Zip _____ County _____

Home phone _____ Work phone _____ext._____ Cell phone _____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced Patient E-mail Address_____

Highest level of education: ☐ GED ☐ High School ☐ BA ☐ BS ☐ Masters ☐ PHD ☐ Other _____

Patient Pharmacy _____ Pharmacy Phone _____

Preferred Language: ☐ English ☐ Spanish ☐ Other _____ Need Interpreter? ☐ Yes ☐ No

Ethnic Background: ☐ Hispanic/Latino ☐ Not Hispanic/Not Latino ☐ Other_____

Race: ☐ Ame. Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ White/Not Hispanic ☐ Other _____

Employer: _____ Employer Address _____

Employment Status: ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Retired ☐ Active Duty Military ☐ Disabled ☐ Student FT/PT

Job Title: _____

Is this visit due to an accident? ☐ Y ☐ N If yes, explain: _____ Is this visit job related? ☐ Y ☐ N

Date of injury: _____/_____/_____ Supervisor name: _____ Phone: _____

Emergency Contact

Name_____ Relationship _____ Phone _____

Responsible Party Information

Name_____ Home phone _____ Cell phone_____

Relationship to patient _____ ☐ Male ☐ Female Date of birth: _____/_____/_____ Soc. Sec. #_____

Address _____ City_____ State _____Zip _____

Employer _____ Employer Address _____

Employment Status: ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Retired ☐ Active Duty Military ☐ Disabled ☐ Student FT/PT

Primary Insurance

Insurance Co. _____

Group # _____ Policy # _____

Subscriber _____

Relationship to Patient: _____ Date of Birth: ___/___/___

☐ Male ☐ Female Soc. Sec. # _____ Phone _____

Employer _____

Address _____

Secondary Insurance

Insurance Co. _____

Group # _____ Policy # _____

Subscriber _____

Relationship to Patient: _____ Date of Birth: ___/___/___

☐ Male ☐ Female Soc. Sec. # _____ Phone _____

Employer _____

Address _____

_____ Date_____

Signature of patient or person authorized to sign for patient

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AUTHORIZATION TO LEAVE MESSAGES

Patient Last Name _____ First Name _____ Middle Initial _____ Suffix _____ (Jr/Sr/II etc.)

Address _____ City _____ State _____ Zip _____

Date of Birth _____/_____/_____

Which of the following communications means are appropriate/acceptable for BMG to communicate with you: (please check all that apply)

☐ Home phone # _____ ☐ Okay to leave a message? ☐ Yes ☐ No

☐ Cell phone # _____ ☐ Okay to leave a message? ☐ Yes ☐ No

☐ Work phone # _____ ☐ Okay to leave a message? ☐ Yes ☐ No

Which method of communication is preferred? ☐ No contact ☐ Mail ☐ Phone ☐ Email ☐ Mychart

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With whom may we share information about your health? Please list below.

Note: In order for BMG to disclose your Private Health Information, the representative listed must be able to provide (2) two of the (3) identifiers listed below:

1. Last 4 digits patient's social security number 2. Patient's date of birth 3. Patient's zip code

AUTHORIZATION TO DISCLOSE HEALTHCARE INFORMATION

Name	Relationship to You	Telephone Number	May Discuss Diagnosis/Treatment	May Discuss Billing Info
_____	_____	_____	☐ Yes ☐ No	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No	☐ Yes ☐ No

Do you have a legal document that states who will make decisions if you are unable? ☐ Yes ☐ No

If yes, Name _____ Relationship to Patient _____

Check one: ☐ Healthcare Proxy/Agent ☐ General Power of Attorney ☐ Healthcare Power of Attorney

If you would like information about appointing a healthcare proxy/agent, please let us know.

I understand that it is my responsibility to update this list in order to keep accurate those authorized persons to discuss and use the patient's healthcare information.

Patient/Legal Representative Signature: _____ Date: _____

OFFICE USE ONLY – Document should be Scanned under Ambulatory Auth and Consent Doc type

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Authorizations & Acknowledgments

Date: _____ MRN_____

Patient Name: _____
First Middle Last

Acknowledgment of Notice of Privacy Practices

Initial Here _____ I acknowledge that a copy of the Notice of Privacy Practices was provided to me.

General Consent to Treatment and Test

Initial Here _____ I am voluntarily seeking medical treatment. I consent to examination by the physician, nurse practitioner, nurse and other health care professionals at this clinic. I also consent to any medical procedures, x-ray, laboratory tests or other health care services ordered by the health care team. I understand that I may refuse specific treatments or procedures by informing the health care team.

Release of Information

Initial Here _____ I authorize Baptist Medical Group to release any medical information necessary to process payment of my claim.

Assignment of Insurance Benefits and Acceptance of Financial Responsibility

Initial Here _____ I authorize payment directly to Baptist Medical Group for their fees. I understand and agree that if any part of my account is not paid by insurance, I am financially responsible. I also understand that I may qualify for financial assistance for services provided by Baptist Medical Group and that I may request an application to apply for financial assistance. I further understand that the determination of whether I qualify for financial assistance is dependent upon my timely submittal of appropriate financial documentation and my failure to provide any such documentation could affect my ability to qualify for financial assistance.

Communications Regarding My Account

Initial Here _____ I agree that the facility, Medical Financial Services, Inc. or any other collection or servicing agency or agencies retained by the facility or my physicians (together referred to hereafter as "collectors") to collect any money that I owe to the facility may contact me by telephone or text message at any number given by me or that is or becomes associated with me or my account from sources other than me, including but not limited to, cellular/wireless telephone numbers which may result in my incurring fees for the call or text message. I understand, acknowledge and agree that the collectors may contact me by automatic dialing devices and through pre-recorded messages, artificial voice messages or voice mail messages. I further agree that the collectors may contact me using e-mail at any e-mail address I provide to the facility or is otherwise associated with my account.

Destruction of X-ray Images/Graphic Data (MS Patients Only)

Initial Here _____ I hereby authorize the entity to retire x-ray images and other graphic data which may be generated during my care (treatment, testing, or otherwise) four years after the time generated if a proper report is in the medical record.

_____
Signature of patient/parent/guardian/person authorized to sign for patient

Date: _____