PATIENT INFORMATION: **TODAY'S DATE**_____

Last Name: _____ First Name: _____ Middle Initial:_____

Date of Birth: _____ Sex:____Male____Female SS#:_____ Marital Status:_____

Street Address:_____City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Email:_____Contact Preference: (Home Phone) (Work Phone) (Mobile Phone) (Mail) (Patient Portal)

AUTHORIZATION: I authorize you to leave automated reminder calls on my mobile device ____YES ____NO

Referring Provider:_____ Patient PCP: _____

Race: (Arab) (Asian) (Black or African American) (Other Race) (White) (Other) Preferred Language: English Other _____

Ethnicity: (Central American) (Cuban) (Dominican) (Hispanic or Latino/Spanish) (Latin American/Latin, Latino) (Mexican) (Not Hispanic or Latino) (Puerto Rican) (South American) (Spaniard)

How did you hear about us? (Physician) (Internet Search) (Newspaper) (Television) (Hospital Partner) (BHS Screening Bus) (Baptist Community Event) (Website) (Insurance Company) (Baptist Emergency Hospital) (Friend/Family) (Employer) (Other_____)

GUARDIAN INFORMATION:

Guardian Last Name:_____Guardian First Name:_____M. Name:_____

EMERGENCY CONTACT INFORMATION:

Last Name:_____First Name:_____Phone:_____Relationship:_____

INSURANCE INFORMATION: *Please bring insurance card(s) to the visit*

Insurance Plan Name:_____Policy Holder Name:_____Policy Holder DOB: _____

EMPLOYER INFORMATION:

Employer Name:_____Employer Phone:_____Occupation:_____

CLINICAL INFORMATION:

Preferred Pharmacy:_____Phone:_____Fax: _____

Preferred Laboratory: _____

Protected Health Information Authorization:

Please list any family members or others who may be involved in coordinating your care or payment for care. Also, indicate what kinds of information may be shared with each individual.

Name	**Relationship to Patient**	**Type of information**			
		All	**Schedule**	**Medical**	**Billing**
_____	_____	**Y/N**	**Y/N**	**Y/N**	**Y/N**
_____	_____	**Y/N**	**Y/N**	**Y/N**	**Y/N**
_____	_____	**Y/N**	**Y/N**	**Y/N**	**Y/N**
_____	_____	**Y/N**	**Y/N**	**Y/N**	**Y/N**

Specific Instructions or Limitations:_____

We will continue to rely on the information given here when communicating with family members or others involved in you care unless you request changes. Please promptly notify our office if you wish to alter the designations above.

Signature of Patient:_____**Date:**_____

To revoke this authorization, please send a written request to our office.

POLICY ACKNOWLEDGEMENTS AND RELEASES

Please read each of the following statements carefully and sign as your authorization, understanding, and agreement to each statement.

ASSIGNMENT AND RELEASE: I hereby assign my insurance benefits to be paid directly to the physician. I also authorize the physician to release any information required to process this claim to my employer, prospective employer and/or insurance carrier.

Signed:_____ Date: _____

MEDICARE BENEFICIARY ASSIGNMENT AND RELEASE: I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by_____. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

Signed:_____ Date: _____

FINANCIAL OBLIGATION: I hereby acknowledge that I understand there may be services provided that will not be covered by my insurance carrier, and fully understand that I am fully responsible for any and all charges not covered by my insurance carrier. I understand that payment may be requested at the time of service or I may be billed for such services subsequently.

Signed:_____ Date: _____

CONSENT FOR TREATMENT: I hereby authorize the physician, nurses, medical assistants and staff to conduct such examinations, and to administer treatment and medications as they deem necessary and advisable.

Signed:_____ Date: _____

ADVANCED DIRECTIVE: Do you have an advance directive (living will/power of attorney)?

_____Yes _____No If yes, please provide a copy for our records.

MEDICATION HISTORY AUTHORITY: I authorize BHS Physicians Network and BHS Physicians Specialty to obtain Medication History Authority.

Signed:_____ Date: _____

NO SHOW POLICY

Patients who fail to present for a scheduled appointment will be considered a “no show”. Patients who fail to cancel the appointment 24 hours prior to the appointment will also be considered a “no show”.

A patient determined to be a “no-show” will be charged $25.00 for each episode.

Patients who have missed 3 appointments in a 12 month period will be considered a “chronic no show”. A patient determined to be a “chronic no show” may be discharged from the practice.

_____ has read and understand the above stated policy.
Patient Signature

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: You may refuse to sign this acknowledgement.

I,_____, DOB,_____,

have received a copy of this office's Notice of Privacy Practices.

_____
Print Name

_____
Signature

_____
Date

For Office Use Only:

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

_____Individual refused to_____accept Notice_____sign Acknowledgment

_____Communications barriers prohibited obtaining the acknowledgment

_____An emergency situation prevented us from obtaining acknowledgment

Other (Please specify)_____

We appreciate the opportunity to serve you. The following information and expectations are set forth in an effort to provide all our patients with the highest quality care:

____ **MEDICATION REFILL REQUESTS:** We request that you first contact your pharmacy for refills. We will not do same day refills. The pharmacy will work with us to process your requests. Refills should be requested at least 72 hours (3 business days) prior to your refill date. We do not give one year prescription refills. The practice is closed on weekends and refill requests will not be accepted. Please contact our office to confirm that we have received the refill request.

____ **PAYMENTS:** All applicable fees, deductibles, coinsurance, co-pays or outstanding balances must be paid at the time of your appointment. We accept cash, checks, Visa, MasterCard, Discover and American Express. There is a $25 charge for all returned checks.

____ **CHANGES OF INFORMATION:** Please provide us with any changes regarding your address, phone number or insurance information as soon as possible. Failure to notify us of any updates may result in you being financially responsible for the services rendered.

____ **FMLA & OTHER FORMS:** Should you require our office to complete FMLA or other applicable forms, there is a fee starting at $35. Fees are due when forms are completed. Please allow 7 business days for us to complete forms. Please inquire with the staff regarding forms that need to be completed and applicable fees.

____ **APPOINTMENT TIME:** We ask that you arrive on time for your appointments. Arrivals later than 15 minutes will require appointment rescheduling.

____ **CELL PHONES:** We ask you to please have your cell phone off during your office visit.

____ **CANCELLATION/NO SHOWS:** If you need to cancel your appointment, we ask that you give us 24 hours notice. If you fail to notify us and miss your appointment, there will be a $25 fee and possible termination from the office if excessive. There will also be a fee of $25 if you cancel your appointment on the same day.

____ **LAB & RADIOLOGY RESULTS:** Once reports are received, the physician will review the results and have our clinical staff contact you within 10 business days.

____ **Office Visits:** At the time of scheduling, please notify the staff of all the reasons for which you are requesting an appointment. In respect to all our patients' time and to maintain the efficiency of the practice, only complaints for which the visit was scheduled will be addressed. We will address all your healthcare needs, but it may require multiple visits.

We ask that you initial each area and sign below. By signing below, you acknowledge having read, understood and are in agreement with the above information and expectations.

_____	_____	_____
Patient Signature	**Printed Name**	**Date**

New Patient Questionnaire:

Patient Name:_____ Date of Birth: _____

CURRENT MEDICAL PROBLEM

What problem brought you here? _____
What symptoms are you having? _____
When did the symptoms begin? _____
Has your appetite changed in the last six months? Increased Decreased stayed the same
Has your weight changed in the last six months? No Yes If yes, Gained_____lbs Lost_____lbs
Has your overall energy level changed? Increased Decreased stayed the same

ALLERGIES

Are you allergic to any medications, pills, food, etc.?

Drug/ Allergen	Reactions?	Onset Date:

MEDICATIONS

Please list all medications or pills that you take, that you do not utilize your insurance to obtain or that are not prescribed by a physician. Please include all vitamins, herbal supplements, and/or over the counter medications.

Medicine or pill name	Dose (e.g., 50 mg)	How many times per day?	Why do you take this?

VACCINATIONS

Have you received a pneumonia vaccine with the past 5 years? No Yes, date _____ Don't know
Have you received a flu vaccine this season? No Yes, date _____ Don't know
When was your last tetanus? Date: _____ Don't know

PAST MEDICAL / SURGICAL HISTORY

Please circle Yes or No to any medical problems.

Anemia Y / N
Anxiety Y / N
Arthritis and/or Gout Y / N
Asthma Y / N
Bleeding Problems Y / N
CAD Y / N
CHF Y / N
Cancer (If yes, specify type) Y / N
Convulsions/Seizures Y / N
Dental/Oral Problems Y / N
Depression Y / N
Diabetes Y / N
Gastritis/Ulcer Y / N
HIV/AIDS Y / N
Headaches/Migraine Y / N
Hepatitis Y / N
High Blood Pressure Y / N
High Cholesterol Y / N
Kidney Disease/Stones Y / N
Overweight/Obesity Y / N
Pneumonia Y / N
Sexually Transmitted Disease Y / N
Stroke Y / N
Thyroid Disease Y / N
Tuberculosis (or positive Tb test) Y / N

SURGICAL HISTORY

Please list any previous operations or procedures

Procedure / Operation	Date	Surgeon	Hospital

Patient Name:_____ Date of Birth: _____

FAMILY HISTORY

Relation:	Problem: Ex: Stroke, Heart Disease, Diabetes, Hypertension, etc.,	Onset Age	Died of Age	Notes

SOCIAL HISTORY:

Please circle or complete the most applicable.

Smoking Status: Never Smoker/ Former Smoker/
Current every day smoker
If so, Has smoked since age: _____
If so, How much: None/ 1 PPW /2 PPW/ 1/4 PPD/ 1/2 PPD/ 1 PPD
1 1/2 PPD/ 2 PPD/ 3+ PPD
Chewing tobacco : None/ 1 day/ 2-4 day/ 5+/day
Exercise level: None/ Occasional/ Moderate/ Heavy
Diet: Regular/ Vegetarian/ Vegan/ Gluten free
Specific / Carbohydrate

General Stress Level: Low/ Medium/ High
Alcohol intake : None/ Occasional/ Moderate/ Heavy
Caffeine intake: None/ Occasional/ Moderate/ Heavy
Illicit drugs : _____
Sunscreen used routinely: Y/ N
Does anyone living in your home smoke? Yes/ No

GYN HISTORY

Number of pregnancies: _____
Number of live births: _____
Number of miscarriages: _____
Number of abortions: _____
Age at Menarche: _____
If Post-Menopausal, Age at Menopause: _____
Duration of Flow (days) : _____
LMP: Unknown / Approximate/ Definite
Menses Monthly: Yes/ No
Current Birth Control Method: BCPs/ UD/ Diaphragm/ Tubal Ligation/ Partner Vasectomy/ Depo-Provera/ Condoms/ None
Hormone replacement: Yes/ No

QUALITY METRICS

Test or Measure	Date Last Completed	Physician/Location Performed By
Colonoscopy (all patients 50-75)		
Mammogram (female patients 40-69)		
Cervical Cancer Screening/ PAP (female patients 21-64, every 3 years)		
Pneumonia Vaccine (patients 65 and older)		

I understand that Quality Measures are ordered by my doctor to aid in prevention and diagnosis. I understand that by not having thse measures done, I am going against the medical advice of my doctor