Baptist Health

Baptist Health Family Clinic - West

Full Name:		Social Security Number:	
Date of Birth:	Age:	Marital Status:	
Legal Sex: ☐ Male ☐ Female	Sex assigned at birth: ☐ Male ☐ Female ☐ Decline to Report		
Address:	City:	State:	Zip Code:
Race (Select all that apply): ☐ American Indian and Alaska Native ☐ Asian ☐ Black or African American ☐ White or Caucasian ☐ Native Hawaiian or Other Pacific Islander ☐ Other ☐ Unknown ☐ Decline to Report			
Ethnicity (Select one): ☐ Non-Hispanic ☐ Hispanic ☐ Unknown ☐ Decline to Report			
Gender Identity: ☐ Male ☐ Female ☐ Transgender Female ☐ Transgender Male ☐ Other ☐ Decline to Report			
Sexual Orientation: ☐ Straight ☐ Lesbian or Gay ☐ Bisexual ☐ Something else ☐ Decline to Report			
Preferred Language:	Do you need an interpreter? ☐ Yes ☐ No		
Phone:	Cell:	Email:	
Preferred Method of Contact (Select all that apply): ☐ MyChart ☐ Phone ☐ Email ☐ Text Message ☐ Mail			
Employment Status: ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Retired ☐ Student ☐ Homemaker ☐ Decline to Report			
Highest level of schooling you have received: ☐ Not a high school graduate ☐ GED ☐ High school graduate ☐ Some college ☐ Associate's Degree ☐ Bachelor's Degree ☐ Master's Degree ☐ Doctorate or Professional Degree ☐ Decline to Report			
Pharmacy:	Previous Primary Care Physician:		
Employer:	Work Phone:		

EMERGENCY CONTACT

Name:	Relationship:	Phone:	Cell:	
Address:	City:	State:	Zip Code:	**Approved HIPAA Contact? ☐ YES ☐ NO**

GUARANTOR INFORMATION (Person/Entity financially responsible for the patient)

Name:	Relationship:		
Social Security Number:	Date of Birth:	Phone:	
Address:	City:	State:	Zip Code:
Employer:	Work Phone:		

INSURANCE INFORMATION

Primary Insurance:	Secondary Insurance:
Mail Claims To:	Mail Claims To:
Group No.: ID No.:	Group No.: ID No.:
Subscriber's Name:	Subscriber's Name:
Relationship to patient:	Relationship to patient:
Subscriber's Date of Birth:	Subscriber's Date of Birth:
Subscriber's Employer:	Subscriber's Employer:

AUTHORIZATION TO TREAT MY CHILD (if applicable)

List below any persons that you give permission to accompany your child for medical treatment (other than parent or guardian):

Name:	Relationship to You:	Telephone Number:	
			☐ **Approved HIPAA Contact?**
			☐ **Approved HIPAA Contact?**

AUTHORIZATION, CONSENT, AND ACKNOWLEDGEMENT

I hereby authorize my insurance benefits to be paid directly to BHFC - West. I consent to the use or disclosure of my protected health information by BHFC - West for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of BHFC - West have the right to revoke this consent in writing at any time, except to the extent that BHFC - West has taken action in reliance on this consent. The Notice of Privacy Practices for BHFC - West has been provided to me.

Signature of Patient or Guardian

Date

Baptist Health Staff: This form should not be altered in any way. Please contact laura.lawrence@practice-plus.com to access the electronic copy of this form.

MEDICAL HISTORY / HEALTH QUESTIONNAIRE

Patient Name: | Date of Birth:

Current Medications

Medication Name/Dosage (mg) How Often do you take it?

Include all prescriptions and over-the-counter medications. If more space is needed, please use the back of this form.

1 | 5

2 | 6

3 | 7

4 | 8

Preferred Pharmacy:

Allergies

☐ Answered Online

Indicate the allergens and the reaction that you have to those allergens.

Preventive Medicine

☐ Answered Online

Please answer the following questions as appropriate for age and sex. MM/YY

Last Physical		Last Prostate Check	
Last Tetanus		Last Pneumonia Shot	
Last Colonoscopy		Last Influenza Shot	
Last Mammogram		Last Shingles Shot	
Children: Are immunizations up-to-date?		Pap Smear	

Past Medical History

☐ Answered Online

Check all that apply

☐Diabetes ☐Hepatitis ☐Blood Clot ☐Cancer ☐Ulcers or Reflux ☐High Blood Pressure ☐Heart Disease

☐Glaucoma ☐Seizures ☐Fibromyalgia ☐Stroke ☐Bleeding Disorder ☐Emphysema/COPD ☐Tuberculosis

☐Asthma ☐Arthritis ☐Migraines ☐Anemia ☐Thyroid Disease ☐Elevated Cholesterol ☐Kidney Disease

☐Allergies ☐STDs ☐Liver Disease ☐Ulcers ☐Constipation ☐Depression/Anxiety ☐Mental Illness

Other Pertinent Medical History: _____

Surgical History

☐ Answered Online

List the operation/procedure and the year in which it occurred.

Family History

☐ Answered Online

Mother's: Name _____ Deceased ☐ Yes ☐ No

If yes, at what age? _____ Cause? _____

☐Cancer (Type): _____	☐Heart Disease	☐Stroke	☐High Blood Pressure	☐Diabetes
☐Heart Attack	☐Lung Disease	☐Kidney Disease	☐Blood Disease	☐Osteoporosis

Father's: Name _____ Deceased ☐ Yes ☐ No

If yes, at what age? _____ Cause? _____

☐Cancer (Type): _____	☐Heart Disease	☐Stroke	☐High Blood Pressure	☐Diabetes
☐Heart Attack	☐Lung Disease	☐Kidney Disease	☐Blood Disease	☐Osteoporosis

Sibling's (If you have more than two write them down on the back of this form.)

Name: _____ ☐Brother ☐Sister

Deceased ☐ Yes ☐ No If yes, at what age? _____ Cause? _____

☐Cancer (Type): _____	☐Heart Disease	☐Stroke	☐High Blood Pressure	☐Diabetes
☐Heart Attack	☐Lung Disease	☐Kidney Disease	☐Blood Disease	☐Osteoporosis

Name: _____ ☐Brother ☐Sister

Deceased ☐ Yes ☐ No If yes, at what age? _____ Cause? _____

☐Cancer (Type): _____	☐Heart Disease	☐Stroke	☐High Blood Pressure	☐Diabetes
☐Heart Attack	☐Lung Disease	☐Kidney Disease	☐Blood Disease	☐Osteoporosis

Social History

☐ Answered Online

Do you smoke ☐ Yes ☐ No If yes, how much? _____

Do you dip/chew ☐ Yes ☐ No If yes, how much? _____

Do you e-cigarettes? ☐ Yes ☐ No If yes, how much? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how much? _____

Do you drink caffeine? ☐ Yes ☐ No If yes, how much? _____

Do you exercise? ☐ Yes ☐ No If yes, how much? _____

BAPTIST HEALTH FAMILY CLINIC WEST
NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

The signature below acknowledges a copy of this notice was received (not necessarily read).

Date _____

Patient/Legal Representative Signature _____

State Capacity, if Legal Representative _____

This section for internal use only

Lack of patient acknowledgement:
Date _____ Reason _____ Staff signature _____

Designation of
Personal Representative

As part of this clinic's compliance with privacy regulations as set forth by the Health Insurance and Portability Act of 1996, we request that you designate individuals for your physician to discuss your care with.

Upon signing, I understand that my physician may discuss information pertaining to my diagnosis and continuing care with the person(s) listed below.

My signature also allows these designated individuals to discuss my medical bills with the billing office.

Designated individual _____

Designated individual _____

Patient signature _____

Date _____

This form is not to be substituted for a HIPAA authorization form for medical records. Copies of medical records must be processed through the clinic office staff.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____ **Date of Birth:** _____

I hereby authorize the following disclosure of Protected Health Information

Person/Business providing information:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Person/Business receiving information:

Baptist Health Family Clinic West
6015 Chenonceau Blvd Ste 140
Little Rock, AR 72223
Phone: 501-868-8410 / Fax: 501-868-8488

Specific information to be requested or released: Date(s) of Service: _____

- ☐ Visit Notes
- ☐ Radiology Report
- ☐ EKG Results
- ☐ Laboratory Report
- ☐ Medication List
- ☐ Operative Report
- ☐ Consultation
- ☐ History and Physical
- ☐ Physician Orders
- ☐ Immunization Records
- ☐ Entire Medical Record
- ☐ Other _____

The Purpose of this disclosure is:

- ☐ Continuity of Care/Physician
- ☐ Legal Reason
- ☐ Insurance
- ☐ Personal Records
- ☐ School/Work
- ☐ Other _____

I understand that my ability to receive treatment is not conditioned on my signing this authorization.
I understand that I may revoke this authorization at any time by sending a written notice to the clinic. I understand that any release which has been made prior to such revocation and which was made in reliance upon this authorization shall not constitute a breach of my rights to confidentiality.
This authorization will automatically expire in one year.
NOTICE: One your PHI has been disclosed in accordance with this authorization, it may be re-disclosed to individuals or organizations that are not subject to the HIPAA regulations, which means the information may no longer be protected by HIPAA.

_____ _____
Signature or Patient or Legal Representative Date Relationship, if not the patient

_____ _____
Witness Date Witness's Address

SPECIFIC AUTHORIZATION FOR RELEASE OF DRUG/ALCOHOL ABUSE INFORMATION AND/OR MENTAL HEALTH INFORMATION. I acknowledge that data to be released MAY INCLUDE material that is protected by federal law and that applicable to EITHER Drug/Alcohol or Mental Health Information or BOTH. My signature authorizes release of all such information (as specified above and for the purpose mentioned above.)

Signature: _____ Date: _____