baptisthealth centers

PATIENT INFORMATION

NAME (Last, First Middle)			MRN	SSN#	BIRTHDATE	LANGUAGE	SEX
LOCAL ADDRESS	CITY, STATE ZIP		REFERRING PHYSICIAN	SECONDARY/BILLING ADDRESS		ETHNICITY	
HOME PHONE	DAY PHONE	EMAIL ADDRESS	PRIMARY CARE PROVIDER	CITY, STATE ZIP		RACE	
MARITAL STATUS	STUDENT STATUS ☐ Full-Time ☐ Part-Time	SMOKER (Y/N)?	VETERAN (Y/N)?	EMERGENCY CONTACT NAME	CONTACT PHONE	HOME PHONE	

PRIMARY EMPLOYER	SECONDARY EMPLOYER (if Applicable)
ADDRESS	ADDRESS
CITY, STATE ZIP	CITY, STATE ZIP
WORK PHONE	WORK PHONE

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY		POLICY#	
NAME OF INSURED		GROUP#	
ADDRESS OF INSURANCE COMPANY		COPAY AMT $	
CITY, STATE ZIP	PHONE	DEDUCTIBLE $	
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY			POLICY#
NAME OF INSURED	SSN#	BIRTHDATE	GROUP#
ADDRESS OF INSURANCE COMPANY			COPAY AMT $
CITY, STATE ZIP	PHONE		DEDUCTIBLE $
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

Consent for Treatment-I consent to necessary medical treatment as determined by my physician that may be used by the physician/staff of BHC. Assignment of Benefits and Guarantee of Account - I hereby authorize payment directly to BHC, Inc of benefits otherwise payable to me including major medical insurance and payment of surgical or medical benefits. I understand that I am financially responsible to BHC, Inc for charges not covered by this assignment. For services furnished by BHC, Inc I hereby guarantee the payment of all accounts for services rendered. For payment of said accounts for services I hereby agree to pay all costs of collections, including attorney's fees.

SIGNATURE OF PATIENT/GUARDIAN

DATE

baptisthealth centers

Authorization for Patient Information

Release of Information

_____ I DO NOT wish to have test results or other medical information released to any person other than myself except as needed throughout the course of my treatment.

_____ I DO wish to allow BHC to release test results or information regarding my care and treatment to the following person(s):

NAME _____ RELATIONSHIP and Phone Number_____

NAME _____ RELATIONSHIP and Phone Number_____

NAME _____ RELATIONSHIP and Phone Number_____

It is the responsibility of the patient to notify this office of any changes in the above information. If changes do occur, the patient must file another Authorization for Release of Patient Information with this clinic. This authorization is effective until withdrawn.

Please understand that it may be necessary for us to disclose some or all the information contained in your medical records to other physicians, nurses, and/or healthcare providers (collectively referred to as “providers”). At times, other providers assist us in assessing a patient’s condition, screening for potential problems, or providing consultation under certain circumstances. All healthcare providers are required by law to maintain your patient confidentiality.

You agree, in order for us to service our account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any e-mail address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. I/We have read this disclosure and agree that the Lender/Creditor may contact me/us as described above.

Electronic Medical History

E-Prescribing is defined as a physician’s ability to electronically send an accurate, error free, and timely prescription directly to a pharmacy for the point of care. To optimize this electronic capability, and coordinate your care, we ask your permission to obtain electronic medication history of prescriptions prescribed by other providers.

Please select one of the following:

_____ I DO allow my provider to access all of my medication history including medication prescribed by other providers.

_____ I DO NOT allow my provider access to any of my medication history except for prescriptions prescribed in this office or prescriptions recorded in Alabama controlled substance database.

Patient Signature _____ Date _____

Print Name _____ Doctor _____

Witness _____ Date of Birth _____

baptisthealth centers

Patient Preference Form

In an effort to keep you up-to-date with information regarding your personal health care, Baptist Health Centers is dedicated to finding accurate and convenient ways to provide messaging to our patients.

Date: _____

Patient Name: _____ D.O.B._____

What is your Email Address?_____

What is your preferred contact method? (please circle) Home Phone Work Phone Mobile Phone

Please provide your preferred contact number? _____

Who is your Primary Care Physician? _____

Name and location of the pharmacy you would like to use: _____

How Did You Hear About Us?

Baptist Website Newspaper Ad TV Ad Email Facebook Ad Friend/Family

Card/Flyer Google Other Website Community Event

What Prompts Your Visit With Us Today?

Routine Check-Up Wellness Exam Physician Referral Sick Visit

Other: _____

Would you like to be able to communicate with your medical provider or staff by using email?

Sign Up for our Patient Portal today.

Please ask one of our staff members to provide you with your **Portal Token** so that you can register and start using the Patient Portal today.