WELCOME TO BAPTIST PRIMARY CARE - INTERNAL MEDICAL GROUP, INC.

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Please return New Patient Paperwork and a copy of your insurance card 2 weeks prior to your scheduled new patient appointment date. You can return via fax, mail or bring by our office.

PATIENT INFORMATION

DATE & TIME OF FIRST APPOINTMENT:_____ **DOCTOR:**_____ **MRN#**_____

Name:_____ **DOB:**_____ **Today's Date:**_____

REASON FOR TODAY'S VISIT:_____

CURRENT MEDICATION LIST:

Medication Name:_____ Dosage:_____ Instructions:_____
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MEDICATION ALLERGIES:

Medication:_____ Reaction:_____
Medication:_____ Reaction:_____
Medication:_____ Reaction:_____

PREVENTIVE CARE:

Last Physical Exam Date:_____ Location:_____
Last Colonoscopy Date:_____ Location:_____
Last Mammogram Date:_____ Location:_____
Last PSA Date:_____ Location:_____
Last Bone Density Date:_____ Location:_____
Last Pap Smear Date:_____ Location:_____

PHARMACIES: (local & mail order if applicable)

Retail Pharmacy:_____ Address:_____ Phone#:_____
Mail Order Pharmacy:_____ Address:_____ Phone#:_____
Other Pharmacy:_____ Address:_____ Phone#:_____

NAME:_____ **DOB:**_____

CURRENT PROVIDERS:

Provider Name:_____ Date of Last Visit:_____ Specialty:_____
Provider Name:_____ Date of Last Visit:_____ Specialty:_____
Provider Name:_____ Date of Last Visit:_____ Specialty:_____
Provider Name:_____ Date of Last Visit:_____ Specialty:_____

PAST MEDICAL HISTORY:
Circle if you have had any of the following:

Allergies	Angina	Anxiety/Depression	Arthritis	Asthma/COPD
Cholesterol Issues	Colitis	Diabetes	Emphysema/COPD	Epilepsy/Seizures
Gallbladder Disease	Gout	Heart Attack	Hepatitis/Liver Disease	Herpes
High Blood Pressure	Kidney Disease	Lung Disease	Migraine Headaches	Obstructive Sleep Apnea
Other Heart Disease	Rheumatic Fever	STD infections	Stomach Ulcers	Thyroid Disease
Tuberculosis	Urinary Infections			

CANCER:

Type:_____ Date:_____
Type:_____ Date:_____

ADDITIONAL PAST MEDICAL HISTORY: (Not listed above)

Type:_____ Date:_____
Type:_____ Date:_____

REVIEW OF SYSTEMS:
Circle if you have had symptoms WITHIN THE LAST 12 MONTHS:

CONSTITUTIONAL:

Fatigue	Fever/Chills	Malaise	Poor Appetite	Weight Gain
Weight Loss				

EYES:

Discharge	Double Vision	Eye Pain	Itching	Visual Changes

EARS, NOSE & THROAT:

Earache	Hearing Loss	Post Nasal Drip	Sinus Congestion	Sore Throat

CARDIOVASCULAR:

Chest Pain	Claudication	Edema	Palpitations

RESPIRATORY:

Cough	Shortness of Breath on Exertion	Shortness of Breath at Rest	Wheezing

DIGESTIVE:

Abd Pain	Bloody Stools	Constipation	Diarrhea	Dysphagia
Melena	Nausea	Vomiting		

GENITOURINARY FEMALE:

Abn Menses	Dysuria	Frequency	Hematuria	Incontinence
Pelvic Pain	Urgency	Vaginal Discharge	Vaginal Itching	

NAME:_____ **DOB:**_____

GENITOURINARY MALE:

Dribbling	Dysuria	Hematuria	Hesitancy	Impotency
Incontinence	Urgency	Weak Stream		

MUSCULOSKELETAL:

Back Pain	Joint Pain	Joint Swelling	Muscle Aches	Muscle Weakness

SKIN:

Hair Loss	Hives	Itching	Jaundice	Mole Changes
Rash				

NEUROLOGICAL:

Fainting	Falling	Headache	Lightheadedness	Mental Status Change
Motor Weakness	Numbness	Seizures	Vertigo	

PSYCHIATRIC:

Anxiety	Decreased Libido	Depression	Insomnia	Suicidal Thoughts

ENDOCRINE:

Hot Flashes	Night Sweats	Nipple Discharge	Polydipsia	Polyphagia
Polyuria	Temp. Intolerance			

HEMATOLOGIC & LYMPHATIC:

Easy Bleeding	Easy Bruising	Swollen Glands	Nose Bleeds

OTHERSYMPTOMS:_____

LIST ALL PREVIOUS HOSPITALIZATIONS AND SURGERIES:

1._____ YEAR:_____
2._____ YEAR:_____
3._____ YEAR:_____
4._____ YEAR:_____
5._____ YEAR:_____
6._____ YEAR:_____

FAMILY HISTORY:

Mother:_____
Father:_____
Siblings:_____
GrandParents:_____
Aunts:_____
Uncles:_____
Other:_____

NAME:_____ **DOB:**_____

SOCIAL HISTORY:

Do you or have you ever used tobacco products? (cigarettes, cigars, pipes, chew or snuff) YES NO

Do you or have you ever used E- Cigarettes or Vaping? YES NO

How much do/did you use?_____ How long have/did you use? _____

When did you quit?_____ Would you like to quit? YES NO

CurrentOccupation:_____

Do you drink alcoholic beverages? YES NO If so, how much?_____

Do you use illegal drugs? YES NO What kind?_____

How often do you use illegal drugs?_____ With needles? YES NO

Do you have multiple sex partners? YES NO Do you prefer sex with - MEN WOMEN BOTH (circle one)

Have you ever been a victim of a violent act, domestic or otherwise? YES NO

Please explain _____

IMMUNIZATION HISTORY:

Circle if you have had the following immunizations. If so, when:

Gardasil Approx. Date _____

TDAP Approx. Date _____

Tetanus Approx. Date _____

Pneumovax Approx. Date _____

Prevnar Approx. Date _____

Influenza Approx. Date _____

Shingrix #1 Approx. Date _____ #2 Approx. Date _____

Hepatitis A #1 Approx. Date _____ #2 Approx. Date _____

Hepatitis B #1 Approx. Date _____ #2 Approx. Date _____ #3 Approx. Date: _____

Other: _____

BAPTIST PRIMARY CARE-INTERNAL MEDICAL GROUP, INC.
8614 Baymeadows Way, Suite #100
Jacksonville, FL 32256
904-202-1032 - Central Billing Office

Financial Policy Disclosure

Patient Name: _____ DOB: _____

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Please ask us if you have any questions about our fees, financial policy, or your payment responsibility.

____ (initial) **All patients are required to stop at the check-out desk after every visit.**

____ (initial) If you are covered by Medicare, Champus or any of our managed plans, we will file your insurance claim for our professional fees. You are responsible for any co-pay, co-insurance, deductible or non-covered services at the time of service.

____ (initial) If we do not participate with your insurance company, you will be responsible for full payment at the time of service.

____ (initial) All self-pay patients are expected to pay for services in full at the time that services are rendered.

____ (initial) If you receive a bill, you can pay it online at **https://mypay.poscorp.com/BaptistPrimaryCare**

____ (initial) For unaccompanied minors, the parents (or guardians) will be responsible for full payment unless covered by a participating managed plan. Authorization to treat unaccompanied minor must be on file.

____ (initial) In the event your insurance company does not pay the full balance within 90 days, we will notify you so that you may contact your insurance carrier. Please remember that ultimately, payment responsibility rests with the patient. If you do not pay timely and your account is referred to an outside collection agency, you will be responsible for a collection fee in addition to the balance due.

____ (initial) It is our office policy to charge a $40 Missed Appointment Fee for all appointments that are missed or cancelled without 24 hours prior notice.

____ (initial) It is our office policy to charge a $30 Returned Check Fee for any check that is returned by your bank unpaid. I understand that my account could be forwarded to the STATE ATTORNEY'S OFFICE for filing if not reconciled within 7 days of being notified by BPC-IMG.

____ (initial) Baptist Primary Care-Internal Medical Group, Inc. reserves the right to charge a nominal fee for the completion of disability, FMLA and/or other forms.

I understand and agree to the above stated office policies for Baptist Primary Care-Internal Medical Group, Inc.

_____ _____
Signature Date

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS DECLARATION:

I hereby acknowledge that the demographic and insurance information provided to Baptist Primary Care is accurate as of today. I further understand that it is my responsibility to update the office in the event that this information should change. Additionally, I herby authorize Baptist Primary Care to bill my insurance company directly for these services. I authorize any holder of medical or other information about me to release to the Social Security Administration, intermediaries or other insurance carrier any information needed for this or a related claim. I permit a copy of this authorization to be used in place of the original. I hereby ASSIGN BENEFITS to Baptist Primary Care for services rendered.

_____ _____
Signature Date

METHODS OF PAYMENT: CASH, CHECK, VISA, MASTERCARD and DISCOVER

Baptist Primary Care-Internal Medical Group

To comply with the HIPAA privacy rules we require you to tell us how we may contact you and to whom we may release your Protected Health Information (PHI) including medical and financial matters.

Patient Name: _____ DOB: _____ Account: _____

_____
Street Address City, State, Zip

Home Phone: _____ Daytime Phone: _____ Mobile: _____

If you answer "no" to leaving a detailed message we will leave a message with a call back number only.

OK to call my home phone	Y	N	OK to leave detailed message on home answering machine	Y	N
OK to call my daytime phone	Y	N	OK to leave a detailed message on daytime answering machine	Y	N
OK to call my mobile phone	Y	N	OK to leave a detailed message on mobile phone voice mail	Y	N

OK to send faxes to _____ OK to email **non-protected** info to _____

Please provide <u>names and telephone numbers</u> for others we may contact concerning your account or medical care:

OK to call my spouse, _____ at _____

OK to call my caregiver, _____ at _____

OK to call my adult child, _____ at _____

OK to call my parent, _____ at _____

Emergency Contact: _____ at _____

Circle your preferred method of contact and check any additional acceptable methods.

Appointment Reminders ___ home # ___daytime # ___call mobile ___text mobile

List persons you may send to pick up your prescription samples or copies of your medical records:

_____

_____ _____
Signature of patient or representative Date

_____ _____
Representative's relationship to patient Employee Initials & Date

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904-396-0450

DRIVING DIRECTIONS

From Downtown Jacksonville on I-95

1. Go South on I-95 toward St. Augustine.
2. Merge RIGHT onto the Baymeadows Road exit, turn RIGHT onto Baymeadows Road. **Get into the far left lane.**
3. Go 0.4 miles and turn LEFT onto **Baymeadows Way**.
4. Go 0.3 miles and take a LEFT into the parking lot at the IMG Building at 8614 Baymeadows Way. **Entrance is at the rear of the building.**

From Jacksonville via Philips Highway/US-1

1. Go South on Philips Highway/US-1.
2. Pass through the light at Baymeadows Road.
3. At next light **(Baymeadows Way)**, turn LEFT go 0.2 miles.
4. Turn RIGHT into the parking lot at IMG Building at 8614 Baymeadows Way. **Entrance is at the rear of the building.**

From St. Johns County on I-95

1. Go North on I-95 toward Jacksonville.
2. Merge RIGHT onto the Baymeadows Road exit.
3. Turn LEFT on Baymeadows Road.
4. Go approximately 0.5 miles and turn LEFT onto **Baymeadows Way**.
5. Go 0.3 miles and take a LEFT into the parking lot at the IMG Building at 8614 Baymeadows Way. **Entrance is at the rear of the building.**

From St. Johns County via Philips Highway/US-1

1. Go North on Philips Highway/US-1.
2. Turn RIGHT at **Baymeadows Way** (this light is before Baymeadows Road) go 0.2 miles.
3. Turn RIGHT into the parking lot at IMG Building at 8614 Baymeadows Way. **Entrance is at the rear of the building.**

Revised 9/4/14