



BATH COMMUNITY PHYSICIANS GROUP

REGISTRATION FORM

(Please print, complete, and bring to your appointment.)

Today's Date ____/____/____ SSN: _____

Patient's Legal Last Name: _____ First: _____ MI: _____

Is this your legal name? Yes ___ No ___

Street Address: _____ PO Box: _____

City: _____ State: _____ Zip Code: _____

Home Phone (____) - ____ - ____ Cell No: (____) - ____ - ____ Work Phone: (____) - ____ - ____

Primary Care Physician: _____

Birthday ____/____/____ Sex: Male ___ Female ___

Marital Status: _____ Social Security Number ----- _____

Employer: _____ Occupation: _____ Phone: (____) - ____ - ____

Email: _____

Race: _____ Ethnicity: _____

Language: _____ Pharmacy of Choice: _____

Insurance Company: _____

Policy Number: _____ Group Number: _____

Insurance Subscriber: _____ Subscriber Date of Birth: _____

Guarantor Information (Complete Only If Other Than Patient):

Name: _____ Birthday ____/____/____

Street Address: _____ PO Box: _____

City: _____ State: _____ Zip Code: _____

IN CASE OF EMERGENCY

Name of local friend or relative (not living at the same address): _____

Relationship to Patient: _____

Home phone (____) - ____ - ____

Work phone (____) - ____ - ____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Bath Community Physicians Group or my Insurance Company to release any information required to process my claims.

Patient/Parent/Guardian Signature: _____ Date ____/____/____



PATIENT HIPAA ACKNOWLEDGEMENT AND CONSENT FORM

Patient Name: _____ Date of Birth: _____

_____(Patient/Representative initials) **NOTICE OF PRIVACY PRACTICES**

I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my health care information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures. I understand that that I may contact the Chief Compliance Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

_____(Patient/Representative initials) **RELEASE OF INFORMATION**

I hereby permit practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior admission(s) at other BHC affiliated facilities may be made available to subsequent BCH-affiliated admitting facilities to coordinate Patient care or for case management purposes. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under Worker's Compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicare claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records, decreasing the time needed to access my information, aggregating and comparing my information for quality improvement purposes and such other purposes as my be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

DISCLOSURES TO FRIENDS AND/OR FAMILY MEMBERS

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, Findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

PRESCRIPTION PICK-UP AUTHORIZATION

DO YOU WANT TO AUTHORIZE INDIVIDUAL(S) TO PICK UP YOUR PRESCRIPTIONS FOR YOU? IF YES, WHOM?
I hereby authorize the individual(s) listed below to pick up my prescription(s) for me at Bath Community Physicians Group. I understand that my agent/representative must provide valid photo identification each time he/she picks up my prescription(s). This authorization will remain active until I revoke it by contacting the staff at Bath Community Physicians Group.

	Name	Relationship	Contact Number
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Patient/Representative Signature

Date

Note: This clinic uses an Electronic Health Record that will update all your demographics to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated clinics that share an electronic health record in which you have a relationship.

Updated 5/2019



Jeffery McCray, D.O. | Julie Monroe, D.O. | Charles B. Lovelady M.D. FACS
Kimberly Rexrode, FNP | Keith Hummel, M.D. | Scott Crosby, M.D. | Richard A. Wall Jr., M.D. |
Pamela Crance, FNP | Ann May FNP-C | John Stapleton, FNP | Elizabeth Armstrong, FNP-C

Hot Springs—PO Drawer Z, Hot Springs, VA 24445 / Phone: (540)-839-7197 Fax: (540)-839-4831
Covington—322 W Riverside Street, Covington, VA 24426 / Phone: (540)-962-1122 Fax: (540)-962-7881
Covington—713 S. Monroe Ave, Covington, VA 24426 / Phone: (540)-962-1122 Fax: (540)-962-7881
Millboro—432 Church Street, Millboro, VA 24460 / Phone: (540)-997-1447 Fax: (540)-839-4831

Health History Form

Today's Date ____/____/____

Name: _____ DOB: ____/____/____
(Last) (First) (MI)

Please check any health conditions for which you are being treated:

____ High Blood Pressure ____ Arthritis
____ Heart Disease ____ Depression
____ Diabetes ____ Other (Please Specify) _____
____ Thyroid

Past Medical History and Previous Illnesses:

Women Only:

Number of Pregnancies: _____ Birth Control: _____
Date of Last Period: _____ Last Complete Physical: _____

Men Only:

Last Complete Physical: _____

Health Maintenance History (leave blank if never)

Test:

Date of Most Recent:

Cardiac Catheterization ___/___/___

Colonoscopy ___/___/___

Dexa Scan ___/___/___

ECHO ___/___/___

EKG ___/___/___

Mammogram ___/___/___

Pap ___/___/___

Ultrasound Screening for AAA ___/___/___

Prostate Exam ___/___/___

Immunizations:

Date of Most Recent

Influenza (Flu) ___/___/___

Hepatitis A ___/___/___

Hepatitis B ___/___/___

Herpes Zoster(shingles) ___/___/___

Human Papillomavirus ___/___/___

MMR ___/___/___

Meningococcal ___/___/___

Pneumococcal ___/___/___

Tetanus, Diphtheria, Pertussis(Tdap) ___/___/___

Tetanus, Diphtheria (Td) ___/___/___

Varicella (Chicken Pox) ___/___/___

Allergies:

List Food Allergies: _____ Reaction: _____

List Environmental Allergies: _____ Reaction: _____

List Medication Allergies: _____ Reaction: _____

Past Surgeries & Dates

Hospitalizations:

Family History: (Mother, Father, Grandparents, Siblings)

Adopted _____

Members	Status (Alive, deceased, or unknown)	Diabetes	Hypertension	Heart Disease	Stroke	Mental Illness	Cancer	Unknown
Mother		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Maternal Grandfather		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Maternal Grandmother		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Paternal Grandfather		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Paternal Grandmother		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Siblings		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Social History:

Marital Status (circle one): Married Single Divorced Widowed

Number of Children: _____

Employer: _____ Occupation: _____

Tobacco (packs per day) _____ How many years: _____

What Kind (circle one) Cigarettes / Cigars / Smokeless (Chewing tobacco and Snuff)

Alcohol (drinks per week)_____

What Kind:_____

Caffeine (cups per day)_____

What Kind (circle one) Coffee / Tea / Soda

Exercise (days per week)_____

Primary Form(s) _____

Illicit Drugs: Yes_____ No_____

If Yes, what kind _____

Bath Community Physicians Group complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Bath Community Physicians Group does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.