Brattleboro Memorial Hospital
EXCEPTIONAL CARE FOR OUR COMMUNITY

PATIENT REGISTRATION FORM

Please fill out both sides of this form and return it to our office.

PERSONAL IDENTITY INFORMATION*

Last Name: **First Name:** **Middle Initial:** **Gender:**

***While Brattleboro Memorial Hospital recognizes a wide range of personal identities, many insurance companies and legal entities do not. If any of your personal information is different than what is on your insurance card, photo ID, or birth certificate, please list this in the space below. This is important information, as it will help to be sure that charges are billed correctly and that your clinician provides the best care.**

Insurance Name & Gender (if different than above):

Photo ID Name & Gender (if different than above):

Birth Certificate Name & Gender (if different than above):

Race: **Ethnicity:** **Religion:** **D.O.B.:**

Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐Other

Pronouns: ☐She/Her ☐He/Him ☐They/Them ☐Other (Please list):

OTHER PERSONAL STATUS INFORMATION

Do you receive Veteran benefits? ☐ Yes ☐ No **Are you a student?** ☐ Yes ☐ No **If "yes", where?**

Employment Status: ☐ Unemployed ☐ Part-Time ☐ Full-Time ☐ Self-Employed ☐ Retired ☐Other

Is your visit accident related? ☐ Yes ☐ No **Date of accident** **In what state did it occur?**

Employer Name and Address:

Claim #: **Liability Insurance Name and Contact:**

Interpreter Needed? ☐ Yes ☐ No

PERSONAL CONTACT INFORMATION

Mailing Address:

Street Address (if different):

Town: **State:** **Zip:**

Home Phone: **Mobile Phone:** **Other Phone:**

Email address:

Would you like online access to your medical records on the BMH Patient Portal?
If "yes" an invite to the BMH Patient Portal will be sent to your email.
Your answer to the challenge question will be your zip code. ☐ Yes ☐ No

EMERGENCY CONTACT INFORMATION

Last Name: **First Name:** **DOB:**

Home Phone: **Mobile Phone:** **Relationship:**

Last Name: **First Name:** **DOB:**

Home Phone: **Mobile Phone:** **Relationship:**

ADVANCE DIRECTIVE

Do you have an Advance Directive? ☐ Yes ☐ No **If "no", would you like more information or assistance to create one?** ☐ Yes ☐ No

MEDICAL PROVIDER INFORMATION

Primary Care Clinician Name:

Address: **Phone Number:**

Referring Clinician Name:

Address: **Phone Number:**

PRIMARY INSURANCE INFORMATION

Claims are self-pay until complete insurance information is provided.

Insurance Company:

Insured Name on Card **First:** **Last:**

Claim Mailing Address:

City: **State:** **Zip:**

Policy #: **Group #:**

Group Name: **Subscriber's Name:**

Subscriber's DOB: **Subscriber's Employer:**

SECONDARY INSURANCE INFORMATION

Insurance Company:

Insured Name on Card **First:** **Last:**

Claim Mailing Address:

City: **State:** **Zip:**

Policy #: **Group #:**

Group Name: **Subscriber's Name:**

Subscriber's DOB: **Subscriber's Employer:**

GUARANTOR INFORMATION

Complete this section if the patient is less than 18 years old.

Relationship to patient: **Last name:** **First Name:**

DOB: **SSN:** **Home Phone:** **Mobile Phone:**

Mailing Address (if different than patient's address):

Employment: ☐ Unemployed ☐ Part-Time ☐ Full-Time ☐ Self-Employed ☐ Retired ☐Other

Employer Name:

Please initial next to the following statements and then sign below:

_____ I do hereby declare that the above information is true to the best of my knowledge.
_____ I have received notice of BMH Medical Group Privacy Practices, and I understand how the BMH Medical Group can use and disclose protected health information about me.
_____ I do hereby consent to and authorize the performance of all treatments and medical services by the staff of BMH Medical Group and its team which they deem advisable and have discussed with myself and/or my agent.
_____ I understand that I am directly responsible for all charges incurred for medical service for myself and my dependents regardless of insurance coverage.
_____ I hereby Authorize BMH Medical Group to release information requested by the insurance company and/or its representative.

Signature: **Date:**

Name (print): **Relationship to Patient:**

BMH MEDICAL GROUP
a Department of Brattleboro Memorial Hospital

PATIENT HEALTH HISTORY FORM

PERSONAL INFORMATION*

Last Name: **First Name:** **Middle Initial:** **Gender:**

Date of Birth:

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Photo ID Name & Gender (if different than above):

Birth Certificate Name & Gender (if different than above):

Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐Other

Pronouns ☐She/Her ☐He/Him ☐They/Them ☐Other (Please list):

Other Members of Household (Relationships and Ages):

PROVIDER HISTORY

Please list previous clinicians and other medical providers.

Name: **Address:** ☐Current ☐Past

Name: **Address:** ☐Current ☐Past

Name: **Address:** ☐Current ☐Past

CURRENT MEDICAL ISSUES

Please briefly describe any medical issues or concerns that you are currently experiencing.

Reason for Consultation:

MEDICAL HISTORY

Mark the 'C' box for CURRENT conditions and 'P' for PAST conditions

C	P	***Cardiovascular***	C	P	***Cancer***	C	P	***Gyn/Urinary***
□	□	High blood pressure	□	□	Cervical cancer	□	□	Endometriosis
□	□	High cholesterol	□	□	Ovarian cancer	□	□	Frequent UTI
□	□	Heart attack	□	□	Uterine cancer	□	□	Kidney stones
□	□	Blood clots	□	□	Colon cancer	□	□	Kidney infection
□	□	Heart murmur	□	□	Breast cancer	□	□	Blood in urine
□	□	Stroke	□	□	Lung cancer			***Psychological***
		Endocrine	□	□	Skin cancer	□	□	Depression
□	□	Chronic fatigue			***Digestive/GI***	□	□	Alcoholism
□	□	Diabetes □ Type 1 □ Type 2	□	□	Lactose intolerance	□	□	Eating disorder
□	□	Thyroid disorder	□	□	Stomach ulcer	□	□	Other mental illness
□	□	Polycystic Ovary Syndrome	□	□	Crohn's Disease/colitis			***Musculoskeletal***
		Neurological	□	□	Liver disease/Hepatitis	□	□	Arthritis
□	□	Epilepsy	□	□	Hemorrhoids	□	□	Osteoporosis
□	□	Seizures/convulsions	□	□	Diarrhea			***Respiratory***
□	□	Migraines	□	□	Constipation	□	□	Asthma
□	□	Frequent headaches	□	□	Gallbladder disease	□	□	Hay fever/allergies

Other not listed_____

UROLOGICAL HISTORY

Please answer the questions below.

HAVE YOU EVER HAD:
An infection of the kidneys, bladder or urinary tract?
Sexually transmitted disease?
Kidney Stones?
Diabetes?
Heart Disease?
Stroke?

FEMALE PATIENTS ONLY:
How many times have you been pregnant:
How many children have you had?
Were there any problems with any of your pregnancies?

ALLERGIES

Allergen Name	What type of allergic reaction do you have?

CURRENT PRESCRIPTION MEDICATIONS

Preferred Pharmacy:
(name and location)

Medication Name	Dosage	Doses/day	Reason you take this medication	Refill Due Date

CURRENT OVER THE COUNTER MEDICATIONS

Medication Name	Dosage	Doses/ day	Reason you take this medication

SURGICAL HISTORY

Please list any and all surgeries/procedures with dates if you know them.

SUBSTANCE USE

Alcohol Indicate Quantity	☐ Daily	☐ Weekly	☐ Monthly	☐ Yearly	☐ Never
Tobacco Indicate Quantity	☐ Daily	☐ Weekly	☐ Monthly	☐ Yearly	☐ Never
E-Cigarette / Vape *Indicate Quantity*	☐ Daily	☐ Weekly	☐ Monthly	☐ Yearly	☐ Never
Recreational Drugs *Indicate which drugs and Quantity*	☐ Daily	☐ Weekly	☐ Monthly	☐ Yearly	☐ Never
Caffeine *Indicate Quantity*	☐ Daily	☐ Weekly	☐ Monthly	☐ Yearly	☐ Never

FAMILY HEALTH HISTORY

In the space provided, please list any blood relatives who have had the following health conditions. ***Please Indicate paternal or maternal.***

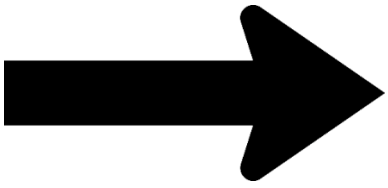
Cancer (type)	Heart Attack
Stroke	Heart Disease
Diabetes	High Blood Pressure
High Cholesterol	Mental/Behavioral
Substance Use	Other

PATIENT HEALTH SCREENINGS

Please indicate the date of your most recent screening and any outcomes or comments.

Screening	**Please check if complete**	**Outcome/Comment/Date of screening if you know**
General Physical		
Dental		
Mammogram		
Colonoscopy		
Pap Smear		
Prostate Exam		
Eye Exam		
Vaccination		

PLEASE CONTINUE TO NEXT PAGE TO COMPLETE REVIEW OF SYSTEMS



REVIEW OF SYSTEMS

Please circle any symptoms you have had in the last 2 months.

Constitutional Symptoms
Fever
Chills
Sweats
Weight change more than 10 lbs.
Loss of appetite

Eyes
Blurred vision
Double vision
Eye pain
Cataract

Ear, Nose, Throat, Mouth
Loss of hearing
Ear pain
Sore throat
Sinus problems

Respiratory
Cough
Shortness of breath
Wheezing
Other

Cardiovascular
Chest pain or pressure
Leg pain with exercise
Varicose veins
Other

Gastrointestinal
Abdominal pain
Nausea or vomiting
Constipation
Diarrhea
Other

Immunologic
Allergies
Frequent or recurrent infections
Other

Neurologic
Headaches
Weakness
Numbness or tingling
Fainting or loss of consciousness
Tremor
Loss of Balance

Genitourinary
Painful urination
Blood in the urine
Difficulty starting urination
Slow urine stream
Urinary frequency
Urgency
Do you wake at night to urinate? _____ How many times? _____
straining to urinate
Incontinence/leakage of urine
Inability to empty the bladder

Adult male patients:
Difficulty with erections
Pain during or after sex
other problems with sexual function
Infertility

Adult female patients:
abnormal vaginal bleeding
Vaginal discharge
Infertility
Painful intercourse
Other sexual dysfunction

Endocrine
Excessive thirst
Excessive hunger
Heat intolerance
Cold intolerance
Severe fatigue

Integumentary
Skin rash
Persistent itch
Boils or other skin infections
Other

Musculoskeletal
Pain or stiffness of the back, neck or joints
Bone pain
Muscle pain
Other

Lymphatic/hematologic
Unusual lumps or masses
Abnormal bleeding or bruising
Blood clots

Psychiatric
Depression
Substance abuse
Anxiety

I acknowledge that I have completed this form to the best of my ability. I realize that any information that I provide on this form will become part of my permanent medical record. I understand that any misrepresentations of my health history may result in an alteration of my current treatment plan, as deemed appropriate by my BMH Medical Group healthcare provider.

Signature: **Date:**

Name (print): **Relationship to Patient:**

Power of Attorney ☐ **Yes** ☐ **No**

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

1. **BY SIGNING THIS FORM, YOU AUTHORIZE BRATTLEBORO MEMORIAL HOSPITAL AND ITS AGENTS TO RELEASE INFORMATION TO OR RECEIVE INFORMATION FROM THE PARTIES LISTED ON PAGE 2 OF THIS DOCUMENT.**

2. **YOU MUST COMPLETE ALL SECTIONS (*). IF ANY (*) SECTION OF THIS FORM IS INCOMPLETE, THIS FORM MAY BE INVALID.**

3. If the patient is 18 years of age or older, the patient must sign and date the form. If the patient is 18 years of age or older and is incapable of signing, a legally authorized representative (Health Care Agent or Legal Guardian) must sign and date the form AND attach supporting documentation.

   If the patient is 17 years of age or younger, the patient's parent or legal guardian must sign and date this form.

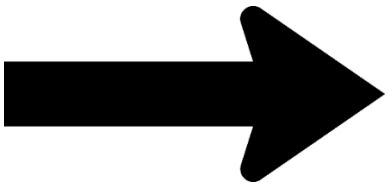
   If the patient is deceased, the "next of kin" or executor must sign and date the form AND attach supporting documentation.

4. If the medical record is complete and contains final copies of all reports, documentation, and appropriate signatures, your request for information will be submitted for processing.

I understand that:

- The information to be released may include information related to Hepatitis, sexually transmitted diseases, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV), behavioral or mental health services, and treatment of alcohol or drug abuse.
- I may be charged a fee for copies in accordance with the state and federal law.
- I have a right to revoke this authorization at any time by submitting a written request to the Department or Office where I originally submitted it. My revocation will not apply to the information that has already been released in response to this authorization.
- Information used or disclosed pursuant to this authorization may be re-disclosed by recipient and may no longer be protected under federal and state law.
- Signing this form is voluntary. I do not need to sign this form to receive health services at Brattleboro Memorial Hospital.
- This authorization will automatically expire **12 months from the date signed** unless otherwise specified:

PLEASE CONTINUE TO NEXT PAGE TO COMPLETE RELEASE OF INFORMATION



BRATTLEBORO MEMORIAL HOSPITAL
17 Belmont Avenue, Brattleboro, VT 05301
Health Information Management
Phone: 802-257-8258
Fax: 802-257-8881

Patient Name _____

Date of Birth _____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (Page 2 of 2)

(*)PERMISSION TO SHARE: I give my permission to share my protected health information. Enter where you would like information sent from, and to whom you would like the information sent.

Patient Address: _____

City:_____ Zip Code: _____Phone #:_____

□ Pick Up □ Send Out

(*)FROM: (e.g. hospital, clinic, or provider name):	**(*)TO: (e.g. to whom you would like information sent):**
Name:_____	Name: BMH UROLOGY
Address:_____	Address: 28 BELMONT AVE
_____	BRATTLEBORO, VT 05301
Fax Number: _____	Fax Number: 802-251-8721
Telephone Number:_____	Telephone Number: 802-251-8720

(*)PURPOSE: (Check the appropriate box)

□ Current Treatment □Provider Transfer □Insurance □Worker's Compensation □Attorney

□ Disability □Personal Records □ Other (please specify):_____

(*) INFORMATION TO BE RELEASED: (Please check all that apply)

□ Hospital Abstract (e.g. History & Physical, Operative Report, Test Results, Discharge Summary)
□ ED Report
□ Discharge Summary
□ Medication List
□ Operative Report
□ Immunizations
□ Clinic Visit Notes
□ Lab Reports
□ Radiology Reports
□ Radiology Images
□ Psychiatric Diagnosis/Treatment
□ HIV/AIDS related illness
□ Drug and Alcohol Treatment
□ Hepatitis Status
□ Other (please specify): _____
_____

VERBAL COMMUNICATION BETWEEN BMH* and: (*BMH will cover all BMH locations)

Name: _____Relationship: _____Phone:_____

Name: _____Relationship: _____Phone:_____

Name: _____Relationship: _____Phone: _____

Dates of Care to be Released: _____ **to**: _____ **(please specify dates)**

_____

Signature of Patient **Date**

_____

Print Name **Description of Authority to Act for Patient (Documents Required)**

For Office use only: Identification verified by (initial):_____(Date):_____ (MRN):_____