BAPTIST HEALTH®

WRITTEN PRESCRIPTION RELEASE FORM

Dear Patient,

In order to release written prescriptions, including controlled substances; to someone other than you it is necessary to have an authorization on file. This authorization allows you the opportunity to designate a specific person(s) to pick up any written prescription medication on your behalf. A valid photo I.D. must be presented each time prescriptions are picked up.

Please note written prescriptions will not be given to anyone you have not listed as an authorized pick up. If at any time you would like to make changes to your approved list, you may do so by completing a new authorization form.

I authorize the following individuals to pick up written prescriptions on my behalf from Baptist Health Medical Group.

Authorized Individual	Relationship to Patient
Authorized Individual	Relationship to Patient
Authorized Individual	Relationship to Patient
Authorized Individual	Relationship to Patient
Authorized Individual	Relationship to Patient

☐ **I do not authorize anyone other than myself to pick up my written prescriptions, including controlled substance prescriptions. I know that if I choose to allow another individual to pick up a written prescription for me, I must complete a new "Written Prescription Release Form".**

Patient Name (Please Print) _____ DOB _____

Patient Signature _____ Date _____

Parent or Guardian (Please Print) _____

Parent of Guardian Signature _____ Date _____

MGE ORTHO LEXINGTON

BH VERBAL RELEASE AUTHORIZATION [Authorization to Verbally Disclose Protected Health Information with Family Member(s) or Other Designated Person(s)]

I _____ hereby authorize **MGE ORTHO LEXINGTON**
(Patient's Name – *please print*) (Provider)

to verbally share the following information:

- ☐ Appointments
- ☐ Payments/Billing
- ☐ Diagnostic procedure results
- ☐ Prescription refills
- ☐ Culture results
- ☐ Lab results
- ☐ Plan of Care/Progress

with the individuals listed below who may be involved with my health care or payment for my health care:

Name:	Relationship to Patient:
_____	_____
_____	_____
_____	_____

☐ I authorize my provider or other staff in his/her practice/department to leave detailed messages regarding the above medical information on my answering machine/voicemail at:

- ☐ Home ☐ Cell/mobile
- ☐ All phone numbers listed

☐ I prefer that my provider or other staff in his/her practice/department speak with me personally regarding my medical information. Do not leave messages concerning my medical information.

I understand that I have the right to revoke this authorization at any time by written notification to **MGE ORTHO LEXINGTON**; however, the revocation will not apply to information that already has been released in reliance upon this authorization. I also understand that this authorization is valid until further notice or written revocation by me. I understand that it is my responsibility to advise **MGE ORTHO LEXINGTON** of changes to my telephone numbers or my preferences regarding telephone messages. I understand that I need not sign this form in order to ensure health care treatment, payment, enrollment in my health plan, or eligibility for benefits. I understand and acknowledge that the confidential health care information disclosed to the above named individuals may be subject to re-disclosure by those individuals and may no longer be protected by federal privacy regulations. The provider expressly reserves the right to disclose information to others who may not be on the list if and to the extent allowed by HIPAA, including but not limited to disclosures for treatment, payment, or healthcare operations.

_____ _____
Patient's Signature (parent/guardian if patient is a minor) Date

Please fill out back of this sheet →

BAPTIST HEALTH
MEDICAL GROUP

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

Current Problem: _____ LEFT RIGHT

Do you have any Allergies: _____

Pharmacy: _____ **Phone:** _____

Medications (please use the back of the page if needed)

Medication	Dose	Frequency	Medication	Dose	Frequency

History
Medical History
_____Diabetes _____Heart Disease _____Osteo Arthritis _____Hypertension _____Blood Clots

OTHER: _____
Surgical History
Have you had any Surgeries: _____
_____

Family History

Cancer	_____Mother	_____Father	Hypertension	_____Mother	_____Father
Stroke	_____Mother	_____Father	Diabetes	_____Mother	_____Father
Osteoarthritis	_____Mother	_____Father	Heart Attack	_____Mother	_____Father

Tobacco
Current Status ____ **Never** ____ **Current Every Day** ____ **Current Some Day** ____ **Former Smoker**

Year Started Smoking? _____ Year Quit? _____

What type _____**Cigarettes** _____**Cigars** _____**Pipe** _____ **Electronic Cigarette**

How many packs daily __ **<1** __ **1** __ **2** __ **>2** How many years did you smoke? _____

Have you ever used **Snuff/Chew Yes or No** **Drug Use Yes or No**

Alcohol **Drinks per day** ___**0** ___**Occasional** ___**1** ___**2** ___**3** ___**>3**

BAPTIST HEALTH
MEDICAL GROUP

Review of Systems – Please check any symptoms that you are currently experience

Constitution
___ Activity change
___ Appetite change
___ Chills
___ Diaphoresis
___ Fatigue
___ Fever
___ Unexpected Wt Change
___ Night Sweats

Eyes
___ Discharge
___ Itching
___ Pain
___ Redness
___ Photophobia
___ Visual Disturbance

Endocrine
___ Cold Intolerance
___ Heat Intolerance
___ Polydipsia
___ Polyphagia
___ Polyuria

Allerg/Immumo
___ Env Allergies
___ Food Allergies
___ Immunocompromised

HENT
___ Congestion
___ Dental Problem
___ Drooling
___ Ear Discharge
___ Ear Pain
___ Facial Swelling
___ Hearing Loss
___ Mouth Sores
___ Nosebleeds
___ Postnasal Drip
___ Rhinorrhea
___ Sinus Pressure
___ Sneezing
___ Sore Throat
___ Tinnitus

Respiratory
___ Apnea
___ Chest Tightness
___ Choking
___ Cough
___ Shortness of Breath
___ Stridor
___ Wheezing

Skin
___ Color Change
___ Pallor
___ Rash
___ Wound

GU
___ Difficulty Urinating
___ Dyspareunia
___ Dysuria
___ Enuresis
___ Flank Pain
___ Frequency
___ Genital sore
___ Hematuria
___ Menstrual Problem
___ Pelvic Pain
___ Urgency
___ Urine Decreased
___ Vaginal Bleeding
___ Vaginal Discharge
___ Vaginal Pain

Neurological
___ Dizziness
___ Facial Asymmetry
___ Headaches
___ Light-headedness
___ Numbness
___ Seizures
___ Speech difficulty
___ Syncope
___ Tremors
___ Weakness

Hematologic
___ Adenopathy
___ Bruises/blds easily
___ Blood Clots

GI
___ Abd Distention
___ Abd Pain
___ Anal Bleeding
___ Blood in Stool
___ Constipation
___ Diarrhea
___ Nausea
___ Rectal Pain
___ Vomiting

Musc
___ Arthalgias
___ Back Pain
___ Gait Problem
___ Joint Swelling
___ Myalgias
___ Neck Pain
___ Neck Stiffness

Psychiatric
___ Agitation
___ Behavior Problem
___ Confusion
___ Decreased Concentration
___ Dysphoric Mood
___ Hallucinations
___ Hyperactive
___ Nervous/anxious
___ Self-injury
___ Sleep Disturbance
___ Suicidal Ideas

Cardiovascular
___ Chest Pain
___ Leg Swelling
___ Palpitations

New Patient / New Problem

Date: _____

Patient Name: _____ **DOB:** _____

Treatment of: Right Left Both Hip Knee Ankle Foot Shoulder Elbow Wrist Hand

Onset: No Trauma Fall Dizziness/Fainting Twisting Injury Direct Blow Other: _____

How long has issue been going on: _____

Pain Scale on average: 0 1 2 3 4 5 6 7 8 9 10

Is your pain: Dull Aching Burning Throbbing Stabbing Shooting

Symptoms: Same as prior Pain Swelling Popping Grinding Stiffness Giving Way

Activity Related Pain: Walking Standing Sitting Climbing Stairs Sleeping Working Leisure

What eases the pain: Rest Ice Heat Medication

Treatments you have tried: Bracing Cane/Walker Anti-inflammatories Physical Therapy Weight Loss Oral Steroids

Injury: No Yes _____ **Worker's Comp** No Yes **Motor Vehicle Accident** No Yes

Occupation: _____ **Lasted day worked** _____

Pain Medication: _____ **Other Medication tried:** _____

Steroid/Visco injections: No Yes- Body Part _____ Date: _____

Previous Surgery on this body part: Type/Date _____ Doctor: _____

Prior Studies: Xray CT scan MRI Bone Scan Lab Nerve Testing Other_____

Current Physical Therapy No or Yes -Where _____

Work Status: Retired Full duty or Restrictions _____

Fevers: _____ **Chills:** _____ **Night Sweats:** _____ **History of Blood Clots:** _____

Established Patient / Follow-Up

Date: _____

Name: _____ **DOB:** _____

Treatment of: Right Left Both Hip Knee Ankle Foot Shoulder Elbow Wrist Hand

How Long has issue been going on? _____

Surgery Follow Up: No or Yes- Side/Part _____

Pain Scale on average: 0 1 2 3 4 5 6 7 8 9 10

Treatments you have tried: Bracing Cane/Walker Anti-inflammatories Physical Therapy Weight Loss Oral Steroids

Symptoms: Same as prior Pain Swelling Popping Grinding Stiffness Giving Way

Activity Related Pain: Walking Standing Sitting Climbing Stairs Sleeping Working Leisure

What eases the pain: Rest Ice Heat Medication

Response to Treatment Improved/Better Unchanged Worse

Current Physical Therapy No or Yes - Where _____

Worker's Comp No or Yes **Work Status:** Retired Full duty or Restrictions _____

Fevers: _____ **Chills:** _____ **Night Sweats:** _____ **History of Blood Clots:** _____