Baptist Health International

BAPTIST HEALTH SOUTH FLORIDA

Smith Road Centre
150 Smith Road, Suite 5
Grand Cayman, Cayman Islands
(345) 749-3304

Date: _____ / _____ / _____

Name: _____ D.O.B. Month _____ / Day _____ / Year_____

Email: _____ Phone/Cell: _____

Address _____

City: _____ Country: _____

Mailing Address: _____

Mailing City: _____ Mailing Country: _____

If seeking treatment in the U.S., local U.S. Phone: _____

If seeking treatment in the U.S., local U.S. Address: _____

Languages Spoken: _____ Diabetic: Yes ◯ No ◯

Race: _____ Religion: _____ Marital Status: _____

Employment Status: _____ Title/Position: _____

Employer Name: _____ Employer Phone: _____

Employer Address: _____

Emergency Contact Person: _____ Relationship: _____

Emergency Contact Phone: _____

Hotel Accommodations Needed?: Transportation Needed?

Method of Payment: Self Pay: _____ Insurance Carrier: _____

Policy/ID Number: _____ Insurance Phone Number: _____

Group Name: _____ Group Number: _____

Name of Primary Insured: _____ D.O.B. (of Primary Insured): _____ / _____ / _____

List any other person that you allow to inquire about or discuss your bill below:

Name: _____ Phone Number _____

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Name: _____ D.O.B. Month _____ / Day _____ / Year_____

Diagnostic / Symptoms:

_____

Additional Notes:

_____

Preferred date for appointment: _____

If seeking treatment in the U.S., travel dates: _____

Referring Physician: _____ Email: _____

Phone: _____ Fax: _____

Cell: _____ Other Phone: _____

Specialty: _____ Sub-Specialty: _____

Hospital Association(s): _____

Private Practice: ☐ Hospital Employee: ☐ Languages Spoken: _____

Primary Care Physician (PCP): _____ Email (PCP): _____

Phone (PCP): _____ Fax (PCP): _____

Please send us the medical orders signed by your physician or any medical reports and images via email to: BHICayman@baptisthealth.net. Please also include a copy of your insurance card (front & back).

Click submit to email this form to Baptist Health: **SUBMIT**