Baptist Health International
Patient Intake Form

BHICayman@BaptistHealth.net| 345-749-3304

Date: _____ / _____ / _____

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

COVID-19 PRE-SCREENING QUESTIONS

At Baptist Health, we place great value on the safety of the patients, families and communities we serve. We are following the Florida Department of Health COVID-19 screening guidelines. Please answer the following pre-screening questions. Note that you may be asked these same or similar questions during your visit to Baptist Health facilities.

1. Have you experienced any of the following symptoms in the last 14 days?

❑ Cough	◯ YES	◯ NO
❑ Shortness of breath or chest tightness	◯ YES	◯ NO
❑ Sore throat	◯ YES	◯ NO
❑ Fever = or >100.4°F (chills/sweats)	◯ YES	◯ NO
❑ Diarrhea	◯ YES	◯ NO
❑ Myalgia (body aches)	◯ YES	◯ NO
❑ New loss of taste or smell	◯ YES	◯ NO

2. Have you been in close contact with someone who has been tested for or diagnosed with COVID-19? ◯ YES ◯ NO

3. Have you been exposed to anyone with COVID-19 at your job? ◯ YES ◯ NO

4. Have you previously tested positive for COVID-19? ◯ YES ◯ NO

5. What countries have you traveled to in the last 14 days? Please list below.

_____

If you answered YES to any of the above questions, you will require further screening. Patients coming for surgical procedures will be tested for COVID-19 during pre-op testing (at least three days prior to surgery). Baptist Health will cancel patient's appointments and/or procedures if patient test positive for COVID.

☐ *Click here to acknowledge Baptist Health COVID-19 Screening Process*

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ADDRESS & DEMOGRAPHIC INFORMATION

Full Address: _____

Country: _____ National I.D. #:_____

Email: _____ Phone/Cell: _____

If different, Mailing Address: _____

If available: Local U.S. Address: _____

If available: Local U.S. Phone: _____

Do you currently have a Visa to enter the United States? ◯ YES ◯ NO

Languages Spoken: _____

Gender?: _____ Race: _____

Religion: _____ Marital Status:

Are you diabetic? ◯ YES ◯ NO

EMPLOYMENT INFORMATION

Employment Status: _____ Title/Position: _____

Employer Name: _____ Employer Phone: _____

Employer Address: _____

EMERGENCY CONTACT

Full Name: _____ Relationship: _____

Email: _____ Phone/Cell: _____

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INSURANCE INFORMATION

☐ *Click here if self-pay*

Insurance Carrier: _____

Policy/ID Number: _____ Insurance Phone Number: _____

Group Name: _____ Group Number: _____

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

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

Name: _____ Phone Number: _____

Please also include a copy of your insurance card (front & back) with this form.

REFERRAL SOURCE AND LOCAL PHYSICIANS

How did you hear about Baptist Health? _____

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): _____

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APPOINTMENT INFORMATION

Preferred date for appointment: _____

Travel dates: Between _____ and _____

Hotel Accommodations Needed?: ○ YES ○ NO

Transportation Needed? ○ YES ○ NO

Diagnostic / Symptoms:

Additional Notes:

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).