Baptist Health South Florida

A. PATIENT INFORMATION

NAME (LAST) (FIRST) (MIDDLE)

PRIMARY ADDRESS | CITY

STATE | ZIP | PREFERRED PHONE | M/S

PCP NAME | RACE | GENDER

RELIGIOUS AFFILIATION | PLACE OF WORSHIP | LANGUAGE

SSN | D.O.B. | ETHNICITY | INTL

OCCUPATION | EMPLOYER NAME

ADDRESS | CITY

STATE | ZIP | WORK PHONE | RETIRE DT

Is this related to an accident? ○ Yes ○ No | ACC DATE

ACC TIME | ACC TYPE | ONSET OF SYMPTOMS

B. GUARANTOR INFORMATION

RELATIONSHIP TO PATIENT

NAME (LAST) (FIRST) (MIDDLE)

PRIMARY ADDRESS

CITY | STATE | ZIP

HOME PHONE | D.O.B. | GENDER | SSN

EMPLOYER NAME | ADDRESS

CITY | STATE | ZIP

WORK PHONE | Does patient have a financial contact? ○ Yes ○ No

FIN CONTACT NAME | PHONE

C. EMERGENCY CONTACT INFORMATION

RELATIONSHIP TO PATIENT

NAME (LAST) (FIRST) (MIDDLE)

ADDRESS | CITY

STATE | ZIP | HOME PH

EMPLOYER NAME | WORK PH

D. INSURANCE INFORMATION

INS CO NAME (**COB1**) | POLICY# | GROUP#

ADDRESS | CITY

STATE | ZIP | PHONE #

Is an authorization, referral, or notification required? ○ Yes ○ No

AUTH# | REF# | BY

INS CO NAME (**COB2**) | POLICY# | GROUP#

ADDRESS | CITY

STATE | ZIP | PHONE #

Is an authorization, referral, or notification required? ○ Yes ○ No

AUTH# | REF# | BY

AMT DUE | NOTIFIED? | REF? | AMT PAID

E. SUBSCRIBER INFORMATION

RELATIONSHIP TO SUBSCRIBER (INSURED)

NAME (LAST) (FIRST) (MIDDLE)

PRIMARY ADDRESS

CITY | STATE | ZIP

HOME PHONE | D.O.B. | GENDER | SSN

EMPLOYER NAME | EMPLOYER PHONE

EMPLOYMENT STATUS

F. OTHER

REASON FOR ENCOUNTER

ATND/ADM NAME | PHONE

REF PHY NAME | PHONE