BAPTIST HEALTH MEDICAL GROUP

Patient Demographic Information Form

Date: _____

Please Print Legibly

Full Name: _____ Date of Birth: _____ SSN: _____

Age: _____ Sex: _____ Marital Status: _____ Email Address: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Ph: _____ Cell Ph: _____ Work Ph: _____

Are you a Baptist Health Employee? *Circle One*: Yes No
If yes, please provide Employee ID: _____
Are you a Veteran? Yes / No

Race: (circle one) White – Black/African American – Asian – Native American/Alaska – Native Hawaiian /Pacific Islander

Ethnicity: (circle one) Hispanic/Latino OR Non- Hispanic/Latino

Preferred Language: _____ Written Language: _____ Needs Interpreter? Yes / No

Emergency Contact: _____ Relationship: _____ Ph: _____

Primary Physician: _____ Ph: _____ Referring Physician: _____

Employer: _____ Ph: _____

Employment Status(circle one): FT – PT – Not Employed – Military Duty – Self Employed – Disabled – Student FT – PT

Pharmacy Name _____ Location _____

Guarantor Information: (Information of person financially responsible for a minor under age 18)

Guarantor Name: _____ Relationship to Patient: _____

SSN: _____ Date of Birth: _____ Sex: _____
Home Ph: _____ Cell Ph: _____ Work Ph: _____
Guarantor Address: _____

City: _____ State: _____ Zip Code: _____

Employment Status(circle one): FT – PT – Not Employed – Military Duty – Self Employed – Disabled – Student FT – PT

Guarantor Employer: _____ Ph: _____

Insurance / Subscriber Information

Primary Insurance: _____ Policy ID#: _____

Group #: _____ Effective Date: _____
Subscriber Name: _____ Subscriber SSN: _____
Subscriber Date of Birth: _____ Relationship to Pt: _____

Subscriber Address: _____

City: _____ State: _____ Zip Code: _____

Secondary Insurance: _____ Policy ID#: _____
Group #: _____ Effective Date: _____
Subscriber Name: _____ Subscriber SSN: _____
Subscriber Date of Birth: _____ Relationship to Pt: _____

Subscriber Address: _____ City: _____ State: _____ Zip Code: _____

BAPTIST HEALTH®
MEDICAL GROUP

Curbside Flu Consent 2023-2024

Patient Name: _____ **DOB:** _____

1. Is the person to be vaccinated sick today or had a fever of greater than 100.4°F in the last 24 hrs? ☐Y ☐N
2. Does the person to be vaccinated have an allergy to latex, mercury, thimerosal, gelatin, chicken eggs/feathers, or other vaccine components? ☐Y ☐N
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past? ☐Y ☐N
4. Has the person to be vaccinated ever had Guillain-Barre syndrome or any other neurological diseases? ☐Y ☐N

I have been given a copy and have read or have had explained to me the U.S. Public Health Service important information statement about influenza vaccine dated 8/6/21. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the risks and benefits of the vaccine and agree to receive the vaccination.

Patient/Guardian Signature: _____ **Date**: _____

Guardian Printed Name: _____

If any above questions are answered "yes", must have provider approval and documentation

Internal Use Only

Vaccine Manufacturer: Sanofi, GSK

NDC#: _____ **Exp:** _____

Vaccine Type: ☐ Fluzone 65+ ☐ Flulaval 6mos+

Administered by: _____

Administration Site: ☐ LD ☐ RD ☐ LT ☐ RT

Date: _____

Time Administered: _____ **Parking Space/Car Number (if applicable):** _____

Time Vehicle Departed: _____ **Patient waited 20 minutes after vaccine administration:** ☐ Yes ☐ No

PATIENT CONDITIONS AND CONSENTS

I understand this authorization is valid until my Baptist account for all services is closed.

1. SMOKE-FREE ENVIRONMENT:

Baptist maintains a smoke-free environment at each of its locations. Smoking is prohibited by health care personnel, patients, and visitors.

2. NOTICE OF NONDISCRIMINATION:

Baptist services, programs and activities are available regardless of race, color, national origin, religion, sex, disability or any other status protected by federal, state or local law.

3. LATEX ALLERGIES: I have a latex allergy ____Yes ____No

4. ADVANCE DIRECTIVES:

- I acknowledge that I have received a copy of a brochure describing my rights to make decisions about my medical care and advance directives or have reviewed this information at https://www.baptisthealth.com/patients-and-visitors/advance-care-planning/advance-directives.

- I have an advance directive (e.g., living will, durable power of attorney, healthcare surrogate) ____Yes ____No

If **Yes**:

☐ I have presented a copy to my physician office.

OR

☐ I do not have a copy, but I have been advised to bring a copy to be placed in my chart. I understand that it is my responsibility to provide the physician's office with a copy of my advance directive.

If **No**:

Would you like more information about advance directives? ___Yes ____No

5. PRIVACY NOTICE AND RIGHTS:

☐ I acknowledge that I have received a copy of Baptist's Notice of Privacy Practices or have the notice at https://www.baptisthealth.com/patients-and-visitors/website-and-privacy-information/baptist-health-medical-group-privacy-notice.

OR

☐ I have previously received a copy of Baptist's Notice of Privacy Practices.

6. CONSENT TO WIRELESS TELEPHONE CALLS:

I hereby authorize Baptist and all third parties, including clinical providers who have provided care to me, along with any billing services, collection agencies, attorneys, business associates making appointment and exam confirmation and reminders, third parties who perform quality surveys, or other agents who may work on their behalf (including their successors, assigns, affiliates, or agents), to contact me at any telephone number associated with my account(s), including wireless telephone numbers or other numbers that may result in charges to me. I agree that methods of contact may include using automatic telephone dialing systems or other computer-assisted technology**.**

PATIENT CONDITIONS AND CONSENTS

7. CONSENT TO EMAIL OR TEXT USAGE FOR HEALTHCARE COMMUNICATIONS:

If at any time I provide an email address at which I may be contacted, I consent to receiving healthcare communication at that email from Baptist. I further consent to Baptist communicating healthcare information, such as appointment reminders, to me on my wireless telephone through text. Baptist participates in Care Everywhere, an electronic exchange of patient data for continuity of care. You may choose to opt out of Care Everywhere by providing a written request to the Health Information Management Department.

PATIENT CONDITIONS AND CONSENTS

The undersigned agrees that a copy of this consent, release and assignment of benefits may be used in place of the original copy. The undersigned authorizes Baptist to appeal on patient's behalf any adverse coverage determinations for treatment or services rendered at Baptist and further authorizes Baptist or its designee to represent patient during any appeal process. The undersigned certifies that he/she has read and agrees to this form and has received a copy.

If the patient is unable to sign, the undersigned Legal Authority certifies that the patient is _____and the undersigned certifies he/she has read and agrees to this consent, release and assignment as a guardian, parent, next of kin, designated surrogate or as a power of attorney (as noted below) and has received a copy. (To the extent that the patient is unable to consent and has been appointed a legal guardian, please provide the name of the guardian and seek the guardian's consent for treatment.)

Patient Name (print): _____

Signature _____ Date: _____

Relationship to patient: _____ Print Name: _____

BAPTIST HEALTH®
MEDICAL GROUP

Curbside Flu Vaccine

I agree to wait the recommended 20-minutes after receiving my flu injection per BHMG policy and recommendation of the Immunization Action Coalition (IAC). I agree that I will wait this 20 minute period at the office of the BHMG location where I receive my flu injection. I understand that I may be asked to wait this 20 minute period in the vehicle in which I arrived.

I agree to notify the provider or staff **immediately** if I experience dizziness, lightheadedness, vision changes, and/or any other symptoms outlined in Vaccine Information Statement provided to me prior to receiving my flu injection.

I understand if I refuse to wait 20 minutes after receiving my flu injection and also choose to operate a motor vehicle that it could result in bodily harm and/or loss of life to myself and others.

Printed Name	Date of Birth
Patient Signature (or Legal Guardian Signature)	Date