



Patient Information

(Please print)

Full Legal Name: Last First Middle Preferred Name: Sex: Male Female Date of Birth: Month/Day/Complete Year SS#: Ethnicity: Hispanic/Latino Non-Hispanic/Non-Latino Refuse/Decline Primary Care Physician: Preferred Pharmacy Name: Phone Number: Marital Status: Single Married Divorced Widowed Life Partner Legally Separated Race: Caucasian (white) American Indian African American (black) Hispanic Biracial Asian Oriental Other Unknown Home Address: City: State: Zip: Mail to Address: City: State: Zip: County: Home Phone: Cell Phone: Preferred language: E-mail: Veteran: Yes No Unknown Religion:

Guarantor Information (If guarantor is Self, skip to Emergency Contact)

Parent/guardian presenting minor child for treatment will be listed as the guarantor. If 18 or older, patient will be listed as guarantor and does not have to complete this section. The guarantor will be responsible for any balance due.

Name: Last First Middle Patient relation to Guarantor: Home Phone: Cell Phone: Date of Birth: SS#: City: State: Zip: Country: Home Address: City: State: Zip: Country: Mail to Address (if different): City: State: Zip: Country:

Emergency Contact (Pediatric Patients please list someone other than parent(s)/guardian)

Primary Contact Name: Home Phone: Cell Phone: Patient Relation to Emergency Contact Secondary Contact Name: Home Phone: Cell Phone: Patient Relation to Emergency Contact

Employment

Patient Employer: Work Phone: Ext: Address: City: State: Zip: Employment Status: Full-Time Part-Time Self Employed Active Military Student Full Time Student Part-Time Retired Date Disabled Not Employed Unknown

(Pediatric Patients Only) Parent/Guardian & Immediate Family Information

Mother (If the address, phone numbers and employer information is the same as guarantor, please indicate same.)

Full Name: Last First Middle Nickname: Date of Birth: Month / Day / Complete Year SS#: Home Address: City: State: Zip: Home Phone: Cell Phone: Employer: Work Phone: Ext:

Father (If the address, phone numbers and employer information is the same as guarantor, please indicate same.)

Full Name: Last First Middle Nickname: Date of Birth: Month / Day / Complete Year SS#: Home Address: City: State: Zip: Home Phone: Cell Phone: Employer: Work Phone: Ext:

Patient Name _____

DOB _____

(Pediatric Patients Only) Brothers, Sisters & Other Family Members

Full Name	M or F	Date of Birth	Relationship	Lives with child	
				Yes	No

Check here if no insurance. And, skip to Authorization (below).

Accident Information

Is visit the result of an accident? (Examples: auto accident, workers compensation, etc.) Yes No

Type of Accident: _____ Date of Accident: _____ County of Accident: _____

Primary Insurance Information

Subscriber: This is the person who carries the insurance. If Subscriber is the Patient, skip to Insurance Co Name field.

Subscriber's Name on card: _____ Date of Birth: _____
Month / Day / Complete Year

Patient Relationship to Subscriber: _____ Sex: Male Female

If address and phone number is same as patient, please indicate same.

Address: _____ SS#: _____

City, State, Zip: _____ Home Phone: _____

Employer: _____ Work Phone: _____ Ext. _____

Insurance Co. Name: _____ Phone: _____

Policy/Cert #: _____ Group No: _____ Effective Date: _____

Subscriber Status: Full-Time Part-Time Self Employed Active Military Student Full Time
 Student Part-Time Retired Date _____ Disabled Not Employed

Secondary Insurance Information

SUBSCRIBER: This is the person who carries the insurance. If Subscriber is the Patient, skip to Insurance Co Name field.

Subscriber's Name on card: _____ Date of Birth: _____
Month / Day / Complete Year

Patient Relationship to Subscriber: _____ Sex: Male Female

If address and phone number is same as patient, please indicate same.

Address: _____ SS#: _____

City, State, Zip: _____ Home Phone: _____

Employer: _____ Work Phone: _____ Ext. _____

Insurance Co. Name: _____ Phone: _____

Policy/Cert #: _____ Group No: _____ Effective Date: _____

Subscriber Status: Full-Time Part-Time Self Employed Active Military Student Full Time
 Student Part-Time Retired Date _____ Disabled Not Employed

Authorization

I authorize medical evaluation & treatment, and release of information for insurance/medical purposes concerning my illness and treatment. I hereby authorize payment from my insurance company to the Greenville Health System for services rendered. I will be responsible for any amount not covered by my insurance.

Signature of Patient/Guardian/Guarantor: _____ Date: _____