GREENVILLE HEALTH SYSTEM
UNIVERSITY MEDICAL GROUP

PATIENT REGISTRATION DEMOGRAPHIC

PATIENT INFORMATION (Please print)

Full Legal Name: ______________________ Preferred Name: __________
Last *First* *Middle*

Date of Birth: __________ SS#: __________ Sex: ☐ Male ☐ Female
Month/Day/Complete Year

Ethnicity: Hispanic/Latino ☐
Non-Hispanic/Non-Latino ☐
Refused/Declined ☐

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: __________ Primary Phone: (   ) __________ Secondary Phone: (   ) __________

Preferred language: __________ E-mail: __________

Veteran: ___Yes ___No ___Unknown Religion: __________

GUARANTOR INFORMATION (If guarantor is SELF complete SECTION I only)

***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: __________ Patient relation to Guarantor : __________
Last *First* *Middle*

Primary Phone: (   ) __________

Date of Birth __________ SS#: __________ Secondary Phone: (   ) __________

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: __________ Primary Phone: (   ) __________

Patient Relation to Emergency Contact __________ Second Phone: (   ) __________

Secondary Contact Name: __________ Primary Phone: (   ) __________

Patient Relation to Emergency Contact __________ Second Phone: (   ) __________

SECTION I

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: __________ Nickname: __________
Last *First* *Middle*

Date of Birth: __________
Month / Day / Complete Year

SS#: __________

Home Address: __________ City __________ State________ Zip________
(if different from patient)

Primary Phone: __________ Secondary Phone: (   ) __________

Employer: __________ Work Phone: (   ) __________ Ext__________

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

Full Name: __________ Nickname __________
Last *First* *Middle*

Date of Birth: __________
Month / Day / Complete Year

SS#: __________

Home Address: __________ *(City)* *(State)* *(Zip)*
(if different from patient)

Primary Phone: __________ Secondary Phone: (   ) __________

Employer: __________ Work Phone: (   ) __________ Ext__________

THIS IS A 2 PAGE DOCUMENT

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
				YES NO
				YES NO
				YES NO

☐ ***Check here if NO INSURANCE. Skip to SECTION IV***

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 (If subscriber is SELF complete SECTION II only)

SUBSCRIBER INFORMATION (This is the person who carries the insurance)

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: ______________________________ Primary Phone: ( )

Employer: ______________________________ Work Phone: ( ) ____________ Ext:

SECTION II

Insurance Co. Name: ______________________________ Phone: ( )

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 (If subscriber is SELF complete SECTION III only)

SUBSCRIBER INFORMATION (This is the person who carries the insurance)

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: ______________________________ Primary Phone: ( )

Employer: ______________________________ Work Phone: ( ) ____________ Ext:

SECTION III

Insurance Co. Name: ______________________________ Phone: ( )

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***

SECTION IV

AUTHORIZATION

I authorize medical evaluation & treatment, and release of information for insurance/medical purpose 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:** ______________

Revised:3.21.13

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record. Please answer to the best of your ability.

Name: Preferred Name: Gender: ☐ Male ☐ Female

Date of Birth: Age: Height: Weight:

Occupation:____________________ Employer:____________________
Hobbies: School (if applicable):

What is your hand dominance: ☐ Right ☐ Left ☐ Ambidextrous

Who requested that you visit our office: ☐ Doctor (Please provide full name):____________________
☐ Athletic Trainer: ☐ Friend: ☐ Other: ☐ ER: ☐ Self Referred

Primary Care Physician (if different from above):

Current Medications / Dosages: ____________________
____
____
____

Pharmacy Name (street and city):____________________

Medical History (check all that apply): ☐ High Blood Pressure ☐ Heart Disease ☐ Stroke ☐ Emphysema ☐ Diabetes
☐ Kidney Disease ☐ Hypothyroidism ☐ Hyperthyroidism ☐ Cancer; type ____________
☐ Osteoporosis/Osteopenia ☐ Hepatitis; type ________ ☐ Parkinson's Disease
☐ Other: ____________________ ☐ **None**

Drug Allergies: ☐ **None**

Reaction:
____________ ☐ Rash ☐ Anaphylaxis ☐ Stomach Upset ☐ Hives ☐ Dizziness
____________ ☐ Rash ☐ Anaphylaxis ☐ Stomach Upset ☐ Hives ☐ Dizziness
____________ ☐ Rash ☐ Anaphylaxis ☐ Stomach Upset ☐ Hives ☐ Dizziness
____________ ☐ Rash ☐ Anaphylaxis ☐ Stomach Upset ☐ Hives ☐ Dizziness

Past Surgical History: *Type of Surgery* *Date of Surgery* *Full name of Surgeon*
____
____
____
____

Family History (check all that apply): ☐ High Blood Pressure ☐ Heart Disease ☐ Diabetes ☐ Emphysema ☐ Kidney Disease
☐ Stroke ☐ Cancer ☐ Rheumatoid Arthritis ☐ Other: ☐ **None**

Social History (check all that apply): ☐ *Tobacco Use* ; Type ________ Frequency ________ How long ________
☐ *Alcohol Use* ; Type Frequency ☐ *Drug Use* ; Type Frequency ☐ **None**

REVIEW OF SYSTEMS

Constitutional: ☐ Fever ☐ Weight Loss ☐ Weight Gain ☐ Fatigue ☐ Chills ☐ Night Sweats

Cardiovascular: ☐ Chest Pain ☐ Irregular Heart Beat ☐ Poor Circulation ☐ Leg/Foot Swelling ☐ Leg/Foot Ulcer

Genitourinary: ☐ Blood in Urine ☐ Painful Urination ☐ Unable to Urinate ☐ Difficulty Urinating ☐ Frequent Urination ☐ Bladder Infection

Neurological: ☐ Paralysis ☐ Frequent Headaches ☐ Seizures ☐ Stroke/CVA/ITA ☐ Dizziness ☐ Tremors ☐ Speech Problems ☐ Anxiety/Depression ☐ Feelings of Hopelessness ☐ Sleep Disturbance ☐ Vision Changes

Eyes: ☐ Decreased Vision ☐ Cataracts

Respiratory: ☐ COPD ☐ Asthma ☐Persistent Cough ☐ Shortness of Breath ☐ Wheezing ☐ Pneumonia

ENT: ☐ Loss of Hearing ☐ Sinusitis ☐ Headache

Gastrointestinal: ☐ GERD ☐ PUD/Gastritis ☐ Liver Problems ☐ Stomach Pain ☐ Diarrhea ☐ Abdominal Pain ☐ Nausea/Vomiting ☐ Black tar-like/bloody stool

Skin: ☐ Rash ☐ Dryness of Skin ☐ Skin Ulcers/Open Sores ☐ Skin Cancer/New Moles ☐ Poor Healing ☐ Skin Infection

Psychiatric: ☐ Depression/Anxiety ☐ Bipolar Disease

Endocrine: ☐ Diabetes ☐ Hypothyroidism ☐ Hyperthyroidism ☐ Heat Intolerance ☐ Cold Intolerance

Heme/Lymph: ☐ Anemia ☐ Bleeding Problems ☐ Blood Transfusions ☐ Bruising

Allergic/Immunologic: ☐ Seasonal ☐ Iodine ☐ Food Allergies (please list) :

Musculoskeletal: ☐ Joint Swelling ☐ Muscle Aches ☐ Joint Pain ☐ Pain in Multiple Joints ☐ Weakness

Physician's Initial: ______________ Date: __________

Name: **DOB:**

PAIN AND PROBLEM QUESTIONNAIRE

DATE ___________________

What is the main reason for your office visit today (chief complaint): ☐ Right ☐ Left

Have you had any of the following (pertaining to this problem)? ☐ MRI ☐ X-rays ☐ CT ☐ Other ____________

When did your symptoms first appear? ______________
How long has this problem been present? ______Days ______Weeks ______Months ______Years

How did this begin: ☐ Gradual ☐ Suddenly ☐ After Injury ☐ No Known Mechanism of Injury
☐ Work-Related ☐ Work-Injury ☐ Motor Vehicle Crash

Please provide date of injury or accident:____
Describe injury or accident:____
____

Circle the number that describes your pain **right now**? (for the specific problem you are being seen for today)

No pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

My pain is ☐ Not satisfactorily controlled ☐ Satisfactorily controlled

The pain feels (quality): ☐ Sharp ☐ Stabbing ☐ Dull ☐ Aching ☐ Burning ☐ Throbbing
☐ Other:

The pain is (duration): ☐ Constant ☐ Comes and Goes (Intermittent)

Does your pain move anywhere? ☐ No ☐ Yes; where?

Are there any associated symptoms? ☐ Swelling ☐ Numbness ☐ Tingling ☐ Weakness ☐ Stiffness
☐ Locking ☐ Catching ☐ Giving Away ☐ Other:

Since your problem started, it is: ☐ Getting Better ☐ Getting Worse ☐ Unchanged

What makes your symptoms better? ☐ Rest ☐ Heat ☐ Ice ☐ Elevation ☐ Medication (see below)
☐ Other:

What makes your symptoms worse? ☐ Activity ☐ Exercise ☐ Work ☐ Kneeling ☐ Bending ☐ Squatting
☐ Stooping ☐ Stairs ☐ Hills ☐ Running ☐ Walking ☐ Prolonged Sitting ☐ Other:

Does you pain or problem interfere with any of the following (check all that apply): ☐ General Activity ☐ Sports
☐ Normal Work ☐ Mood ☐ Enjoyment of life ☐ Ability to concentrate ☐ Relationship with others
☐ Other (Explain):

Please check if you are having any of the following?
☐ Fever/chills ☐ Unexpected Weight Loss ☐ Rashes ☐ Night pain ☐ Recent Trauma
☐ Problems with bowel or bladder function ☐ Groin Numbness ☐ Recent bacterial infection
☐ Suppressed Immune System ☐ Intravenous drug use ☐ Pain with coughing or sneezing

Please answer the following questions <u>if you are a post-menopausal woman, or a man over age 65</u>.

1.	Have you ever had a bone density test?	☐ Yes	☐ No
2.	Has someone in your family ever broken a hip or been told they have osteoporosis?	☐ Yes	☐ No
3.	Is your diet low in calcium (avoid milk, cheese, yogurt, lactose intolerant)?	☐ Yes	☐ No
4.	Do you have frequent/chronic diarrhea (Gluten intolerance, malabsorption)?	☐ Yes	☐ No
5.	Do you weigh less than 125 pounds?	☐ Yes	☐ No
6.	Have you fallen down 2 or more times in the last year?	☐ Yes	☐ No
7.	Do you have rheumatoid arthritis?	☐ Yes	☐ No
8.	Have you taken steroids (Cortisone, Prednisone) for 3 or more months in your life?	☐ Yes	☐ No
9.	Have you been treated for cancer with chemotherapy or other medication?	☐ Yes	☐ No
10.	Do you take medication for epilepsy or a seizure disorder?	☐ Yes	☐ No
11.	Do you currently smoke?	☐ Yes	☐ No
12.	Do you drink 3 or more alcoholic drinks per day?	☐ Yes	☐ No
13.	Do you drink 3 or more caffeinated drinks (coffee, tea, soda) per day?	☐ Yes	☐ No
14.	Have you broken any bones (after the age of 50)?	☐ Yes	☐ No
15.	Do you walk or jog for exercise?	☐ Yes	☐ No

Physician's Initial: _______________ Date: ___________

GREENVILLE HEALTH SYSTEM

THE INFORMATION PROVIDED IN THIS FORM WILL BE RELIED UPON BY ALL HEALTH CARE PROVIDERS OF GREENVILLE HEALTH SYSTEM UNLESS REVOKED OR MODIFIED BY THE PATIENT IN WRITING.

AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

Patient Full Name (PRINT) ________________________MRN ___________________ DOB ________________

Authorization for Disclosure of Medical Information: The privacy of your medical information is important. We will discuss your medical condition with person(s) you designate.

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM? *(Check and complete one)*

☐ The following family members or other individuals may receive information regarding my medical condition:
Print first and last name(s) ____
____

OR

☐ Any family member or other individual inquiring about my medical condition may receive information from my provider, EXCEPT the following individuals: *Print first and last name(s)* ______________________________________
____

You may revoke/cancel or modify/change the above designation, but the revocation or modification must be in writing.

NOTE: This designation does not give the above named individuals the right to make health care decisions for you. If at any time you are unable to consent to care or treatment, we will follow the procedure set forth in the South Carolina Adult Health Care Consent Act.

Confidential Communication: Please provide phone number(s) where we can reach you:

☐ Home: _________________ ☐ Work: ________________ ☐ Cell phone: ____________ ☐ Other_____________

Messages: A request for return calls may be left on the following answering machine or voice mail: *(Check all that apply)*

☐ Home ☐ Work ☐ Cell Phone ☐ I do not authorize

I authorize my medical information to be left on the following answering machine or voice mail: *(Check all that apply)*

☐ Home ☐ Work ☐ Cell Phone ☐ I do not authorize

If we are unable to reach you or leave a message at the above phone number(s), please indicate with whom we may leave a message for you to call our facility.

Name ___________________________ Phone Number _______________________

Name___________________________ Phone Number _______________________

Note: *An automated appointment reminder system may call the number listed in our data base.*

Signature: I hereby authorize the disclosure of my medical condition and information as described above.

Patient/Patient's Representative Signature: ____ Date: _______Time:______

PRINT Name (if Patient's Representative): ______________________________________

Relationship to Patient (if Patient's Representative):________________________________

GHS Representative: ____Date: _________Time:_________

Form Create Date: December 30, 2013

GREENVILLE HEALTH SYSTEM

Greenville Health System
University Medical Group*

FINANCIAL POLICY

Please read this financial policy carefully. If you have any questions about this policy, any member of our staff will be glad to assist you.

The following are the conditions for services provided to the patient by Greenville Health System, GHS Partners in Health, and the various entities and providers affiliated with them each individually and collectively referred to as Greenville Health System University Medical Group or GHS UMG.

Payment for Service: Each office will inform you of co-pay and deductible amounts at check in or check out. These amounts are due at the time of service. As a courtesy to you, we will file your insurance claims if you provide us with a copy of your current insurance card. We require that you pay your deductible, co-payment, and/or any charges not covered by insurance.

Method of Payment: You may pay your bill with cash, personal check, certain credit cards, or debit card.

Returned Checks: A $25.00 service charge will be added on all checks returned to us for insufficient funds.

Non-appointment prescription refills: A $15.00 charge per incidence may be added for non-appointment prescription refills.

Non-appointment prescription: A $25.00 charge may be billed to you for new prescriptions filled via phone.

Completion of medical forms: There may be a charge for completion of forms such as disability, camp physicals, etc.

Copies of Medical Records: There may be a charge for completion of this process; SC Sec. 44-7-325 for Health Care Facilities

- $.65 per page for the first 30 pages
- $.50 per page for all other pages
- Clerical fee not to exceed $15.00
- Plus actual postage

No-show Appointments: A fee of $25.00 for a follow up visit and $50.00 for a new patient visit or endoscopy procedure may be charged for all missed appointments not cancelled at least 24 hours prior to the appointment time. You will be financially responsible for the fee, as insurance plans do not cover these charges. You may notify our office of any cancellations by calling during normal office hours.

Payment for Services Provided by Certain Non-UMG Providers: If you are having laboratory and/or diagnostic services by providers other than this office or other practices doing business as GHS University Medical Group, you may be billed separately by that service provider. This includes services provided by Greenville Health System.

Collection Policy: Delinquent accounts will be forwarded to a collection agency. We will inform you of your account status on your statement. If you are unable to pay your balance promptly, please call us at 864-454-2000 or 1-888-284-6024 to make payment arrangements. We will attempt to contact you by letter before your account is forwarded.

Questions: We are here to help should you have any questions regarding your statement or insurance.

GREENVILLE
HEALTH SYSTEM
Steadman Hawkins
Clinic of the Carolinas

Orthopaedic Surgery and Sports Medicine Fellowship Program Disclosure Statement

During your visit today you may be examined by a physician who is participating in the Steadman Hawkins Clinic of the Carolinas Fellowship Program. We have both an Orthopaedic Sports Medicine Fellowship Program and a Nonoperative/Primary Care Sports Medicine Fellowship Program. The programs are accredited one year fellowships in which fully trained orthopaedic surgeons and primary care physicians are chosen from the top medical schools and residency programs across the country to do an additional year of study to focus on shoulder and knee reconstruction and sports medicine. Annually, a group of six physicians are chosen from over 100 applicants to participate in the Orthopaedic Surgery Fellowship Program and two physicians for the Primary Care Sports Medicine Fellowship.

In working with patients, the Fellows will introduce themselves and state that they will be working closely with the consulting doctor in your ongoing care. A plan of treatment is suggested by the Fellow and finalized by the supervising surgeon or physician. In the operating room the fellow will meet with the patient along with the consulting surgeon preoperatively, see patients after surgery with the consulting surgeon on rounds, and may participate in surgical procedures in the operating room.

A Fellow’s role in surgery is under the direct supervision of one of our surgeons who is present at all cases. All patient interaction is done under close supervision of the Steadman Hawkins Clinic physicians. We are also part of the Greenville Health System Orthopaedic Residency Program. Residents are medical doctors in training to become orthopaedic surgeons. They may be involved in your care as well and will perform his/her role under supervision.

Having trained over 150 surgeons world wide, we are proud of our fellowship program. It is one of the best in the country and the only ACGME Accredited Orthopaedic Sports Medicine Fellowship in South Carolina. It is important for our patients and the community to know that this situation provides the best possible medical care for you with a large talented team involved in your care.

Please feel free to ask the Fellow or the consulting physician any questions you might have regarding the Steadman Hawkins Clinic of the Carolinas Fellowship Programs.

______________________________	__________________	________________
Patient Signature	Date of Birth	Date