

PATIENT INFORMATION (Please print)

Full Legal Name: _____ Preferred Name: _____
Last First Middle

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

Primary Care Physician: _____ Ethnicity: Hispanic/Latino
 Non-Hispanic/Non-Latino
 Refused/Declined

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

Date of Birth _____ SS#: _____ Primary Phone: () _____
 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

SS#: _____ Date of Birth: _____
Month / Day / Complete Year

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

SS#: _____ Date of Birth: _____
Month / Day / Complete Year

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

Primary Phone: _____ Secondary 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
				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: _____