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

Today's Date:

PEDIATRIC GI - HEALTH HISTORY

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**

Reason we are seeing the patient:

Please list all prescription and over the counter medications:

Medication	Strength	Frequency taken

List any medical problems that other doctors have diagnosed:

List any allergies to medication or foods:

Surgeries

Mo/Year	Reason	Hospital

Hospitalizations

Mo/Year	Reason	Hospital

Please turn to next page

Name *(Last, First, M.I.):* **DOB:**

FAMILY HEALTH HISTORY

	DOB	SIGNIFICANT HEALTH PROBLEMS	PLEASE CHECK IF THERE IS A FAMILY HISTORY OF THESE DISEASES:	
FATHER			◇ Celiac Disease Who?	◇ Autoimmune Disease Who?
MOTHER			◇ Crohn's Disease Who?	◇ Liver Disease/Hepatitis Who?
SIBLINGS: ☐ M ☐ F			◇ Ulcerative Colitis Who?	◇ Diabetes Who?
☐ M ☐ F			◇ Irritable Bowel Syndrome Who?	◇Gall bladder removed Who?
☐ M ☐ F			◇ Food Allergies Who?	◇
☐ M ☐ F			◇ Migraine Who?	◇
☐ M ☐ F			◇ Colon polyps/Colon Cancer Who?	◇
☐ M ☐ F			◇ Pancreatitis Who?	◇

SOCIAL HISTORY

Is the patient adopted? ☐ Yes ☐ No If yes, please list country of birth:

Who lives in the home with patient? Circle all that apply:

Mother Step Mother Father Step Father Sibling(s) Step Sibling(s) Grandmother Grandfather
Other(s) _____

Are there any unusual stresses at home or at school? If yes, please explain: ☐ Yes ☐ No

Grade in School?

Number of missed days due to GI symptoms:

School performance: Please circle: Excellent Good Fair Poor

Water Supply: Please circle: City Well/Spring Bottled

Have you traveled outside the US in the past year? If yes, please list countries visited: ☐ Yes ☐ No

If over 13 yrs of age, do you smoke cigarettes or use tobacco? ☐ Yes ☐ No

Name *(Last, First, M.I.):* **DOB:**

REVIEW OF SYSTEMS:

Check if patient has had any significant problems with the following

General:
- ☐ Weight loss
- ☐ Excessive weight gain
- ☐ Recurrent fevers

Chest/Heart:
- ☐ murmur
- ☐ chest pain
- ☐ palpitations/heart racing
- ☐ blood pressure problems
- ☐ heart surgery

Hematology/Oncology:
- ☐ anemia
- ☐ prolonged bleeding
- ☐ abnormal bruising
- ☐ history of blood transfusion
- ☐ history of cancer

Lungs:
- ☐ chronic cough
- ☐ asthma/wheezing
- ☐ recurrent pneumonia
- ☐ apnea

Ear/Nose/Throat:
- ☐ Frequent ear infections
- ☐ Sinus problems
- ☐ Frequent mouth ulcers
- ☐ Swallowing problems
- ☐ Hoarseness

Musculoskeletal:
- ☐ joint pain
- ☐ joint swelling
- ☐ muscle weakness
- ☐ scoliosis
- ☐ cerebral palsy

Endocrine:
- ☐ growth problem
- ☐ thyroid problem
- ☐ diabetes

Eyes:
- ☐ Vision problems
- ☐ Wears glasses/contacts
- ☐ Eye pain

Skin:
- ☐ Hives
- ☐ Eczema
- ☐ Acne
- ☐ Other

Bladder:
- ☐ burning or pain with urination
- ☐ urinary incontinence
- ☐ kidney disease
- ☐ urinary tract infection

Neurologic:
- ☐ seizures
- ☐ headaches
- ☐ sensory problems

Allergy/Immunology:
- ☐ environmental allergies
- ☐ food allergies
- ☐ immune deficiency
- ☐ autoimmune diseases

Females: (if applicable)
- ☐ Age at first period _____
- ☐ Date of last period _____
- ☐ Irregular periods
- ☐ Severe cramps
- ☐ Heavy bleeding

Psychological/Developmental:
- ☐ Anxiety
- ☐ Depression
- ☐ Behavior problems
- ☐ Attention deficit/hyperactivity
- ☐ Learning problems
- ☐ Speech delay
- ☐ Motor delay

Other Issues:

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

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