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:** _____
(City) *(State)* *(Zip)*

Address: _____

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#: _____ City _____ State_____ Zip_____

Home Address: _____
(if different from patient)

Secondary Phone: (____) _____

Primary Phone: _____ Work Phone: (____) _____ Ext_____

Employer: _____

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#: _____ *(City)* *(State)* *(Zip)*

Home Address: _____
(if different from patient)

Secondary Phone: (____) _____

Primary Phone: _____ Work Phone: (____) _____ Ext_____

Employer: _____

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* ☐ *not employed* ☐ *student part-time* ☐ *retired* ☐ *disabled* date _____

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* ☐ *not employed* ☐ *student part-time* ☐ *retired* ☐ *disabled* date _____

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

Pediatric Nephrology New Patients

Name: _____ Today's Date: _____
Date of Birth: _____ Age: _____ Grade in school: _____
Primary Care Provider: _____
Parent's Names: _____
Who does your child live with (please identify by name and how they are related):
_____
_____
_____

What is the reason you are here today? _____
_____
_____

When was this problem first noted? _____
_____

Does your child have any other medical or behavioral problems? ☐ No ☐ Yes (please explain)
_____
_____
_____

MEDICATION LIST:

	Name	**Dose**	**Who prescribed this medicine**
1.			
2.			
3.			
4.			
5.			
6.			

Allergies to medications? ☐ No ☐ Yes
Allergy to Latex? ☐ No ☐ Yes
If yes, please list medicine and describe reaction:
_____
_____

Does your child have food allergies or other problems with food? ☐ No ☐ Yes (please explain)
_____
_____

Does your child take a vitamin? ☐ No ☐Yes
Does your child get supplements like pediasure? ☐ No
☐Yes (which one and how much): _____
_____
_____

Birth Weight: _____ pounds _____ oz.

Was your child born:
☐ On time ☐ Late ☐ Early
(how early? _____)

Were there any problems with the pregnancy, delivery, or just after delivery?
☐ No ☐ Yes (please explain)
_____
_____
_____
_____
_____
_____

Patient Name: _____ Date of Birth: _____

Has your child ever had a confirmed urinary tract infection (bladder infection)? ☐No ☐Yes (please list when and how many): _____

Is your child potty trained? ☐not applicable / too young ☐ No ☐ Yes

Age at potty training : Daytime for urine: _____ Nighttime for urine: _____

Age at potty training for bowel movements: _____

Problems with potty training: _____

DOES YOUR CHILD:	**Always**	**Frequently**	**Sometimes**	**Never**
Wet the bed				
Wet during the day (damp underwear)				
Soak underwear during the day				
Delay urinating until the last minute				
Dance/Squat to avoid urinating				
Urinate less than 3 times per 24 hours				
Urinate more than 8 times per 24 hours				
Have pain when urinating				
Wet with laughing, coughing, or straining				
Have a bowel movement every day				
Have problems with constipation				
Have bowel movement accidents in underwear				

Has your child had any surgeries?

☐ No ☐ Yes (list when and for what reason)

Has your child had an overnight hospital stay?

☐ No ☐ Yes (list when and for what reason)

FAMILY HISTORY

Are there any family members (including Mom, Dad, Brothers, Sisters, Cousins, Grandparents, Aunts or Uncles) that have kidney or bladder problems, kidney stones, high blood pressure, or hearing loss at an early age? ☐ No ☐ Yes (if yes, please list relationship to the child, age, and specific illness)

Patient Name: _____ Date of Birth: _____

REVIEW OF SYSTEMS

Please check any of the following problems that apply to your child:

General:
- ☐ Recent weight gain
- ☐ Recent weight loss
- ☐ Growth problems
- ☐ Frequently tired
- ☐ Change in appetite
- ☐ Increased sleeping
- ☐ Increased thirst
- ☐ Frequent fevers
- ☐ Trouble sleeping
- ☐ None of the above

Skin:
- ☐ Rash
- ☐ Easy Bruising
- ☐ Lumps or bumps
- ☐ Stretch marks
- ☐ None of the above

Nervous System:
- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting
- ☐ Change in behavior
- ☐ Seizures
- ☐ Shaking of hands
- ☐ None of the above

Eyes:
- ☐ Redness
- ☐ Vision problems
- ☐ Swelling around eyes
- ☐ None of the above

Ears:
- ☐ Loss of hearing
- ☐ None of the above

Nose:
- ☐ Nasal discharge
- ☐ Nose bleeds
- ☐ None of the above

Mouth:
- ☐ Gum problems
- ☐ Sores in mouth
- ☐ Loss of taste
- ☐ Cavities
- ☐ None of the above

Throat:
- ☐ Recent sore throat
- ☐ Difficulty swallowing
- ☐ None of the above

Heart and Lungs:
- ☐ Chest Pain
- ☐ Irregular heart beat
- ☐ Heart murmur
- ☐ Difficulty breathing
- ☐ Cough
- ☐ Shortness of breath
- ☐ None of the above

Stomach and Intestines:
- ☐ Stomach pain
- ☐ Swelling of stomach
- ☐ Bloody or black stools
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Nausea
- ☐ Constipation
- ☐ None of the above

Kidney and Bladder:
- ☐ Blood in urine
- ☐ Cloudy or dark urine
- ☐ Urine with a foul odor
- ☐ Getting up at night to urinate
- ☐ Low back pain
- ☐ Genital sores
- ☐ Discharge from penis/vagina
- ☐ None of the above

Blood:
- ☐ Anemia
- ☐ Bleeding tendency
- ☐ None of the above

Muscles and Joints:
- ☐ Weakness or tenderness
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Ankle or leg swelling
- ☐ None of the above

Immunizations:

Are shots up to date?

☐ No ☐ Yes

Has your child had the chicken pox vaccine? ☐ No ☐ Yes

Past Diseases:
- ☐ Chicken Pox
- ☐ Measles
- ☐ Mumps
- ☐ Rubella
- ☐ Fifth Disease
- ☐ Strep Throat
- ☐ Scarlet Fever
- ☐ Meningitis
- ☐ Lyme Disease
- ☐ Kawasaki Disease
- ☐ Tick bite
- ☐ HSP (Henoch-Schoenlein Purpura)
- ☐ None of the above

Menstrual:
- ☐ Began menstruating at age: _____
- ☐ Regular periods
- ☐ Irregular periods
- ☐ Missed periods
- ☐ Not applicable

Habits/Lifestyle:
- ☐ Smoking
- ☐ Alcohol use
- ☐ Illegal drug use
- ☐ Sexually active
- ☐ Competitive sports
- ☐ Contact sports
- ☐ Foreign travel
- ☐ None of the above

Patient Name: _____ Date of Birth: _____

PHYSICIAN PROGRESS NOTE

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

AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

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.

Patient Name (PRINT) _____

(For Office Use Only)
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