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

Children's Hospital
Greenville Health System

PEDIATRIC UROLOGY FIRST OFFICE VISIT

Patient Name: _____ D.O.B.: _____

Person Completing Form: _____ DATE: _____

Why is your child coming to see us today? _____

_____

Your Child's Past Medical History:

Please tell us about any other medical problem(s) your child has had. _____

_____

Please tell us about any surgical procedure(s) your child has had: _____

_____

Please tell us about any hospitalization(s) your child has had: _____

_____

Any Allergies? ☐NO ☐YES, please list: _____

Current medications: ☐NONE ☐YES, please list: _____

_____

Your Child's Social History

Who does your child normally live with? _____

Any recent changes in living situation? _____

Does your child attend day care? _____

Children's Hospital
Greenville Health System

PEDIATRIC UROLOGY FIRST OFFICE VISIT

Your Child's Family History:

Please tell us about any ***MEDICAL PROBLEMS*** other family members have:

Father: _____

Mother: _____

Brother(s): _____

Sister(s): _____

Mom's Father: _____ Dad's Father: _____

Mom's Mother: _____ Dad's Mother: _____

Review of Systems:

In addition to the problem we are seeing your child for today, what other problems does he/she have currently?

☐ **Overall healthy**
☐ Unexpected weight gain
☐ Unexpected weight loss
☐ Growth problems

☐ Vision Problems
☐ Recurrent ear infections
☐ Loss of hearing
☐ Nose bleeds
☐ Recent sore throat
☐ Difficulty Swallowing

☐ Irregular heart beat
☐ Heart murmur
☐ Other heart problems

☐ Difficulty breathing
☐ Recent cough
☐ Shortness of breath
☐ Other lung problems

☐ Anemia
☐ Bleeding tendency

☐ Abdominal pain
☐ Abdominal swelling

☐ Constipation
☐ Diarrhea

☐ Difficult urination
☐ Pain with urination
☐ Blood in urine
☐ Cloudy or dark urine
☐ Frequent urination
☐ Urge to urinate
☐ Daytime wetting
☐ Bedwetting
☐ Discharge from penis or vagina

☐ Weakness or tenderness in legs/arms
☐ Joint pain or swelling
☐ Tingling/numbness in legs/arms

☐ Skin Rash
☐ Easy Bruising

☐ Unusual scar formation

☐ Seasonal Allergies
☐ Runny nose

☐ Increased thirst
☐ Change in appetite
☐ Change in menstrual periods

☐ Headaches
☐ Seizures
☐ Fainting spells

☐ Change in Behavior
☐ Extreme mood swings
☐ Emotional problems

Is there anything else you would like to tell us about your child? _____

_____

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.

Date: _____

Children's Hospital
Greenville Health System

Dear Parents:

We have been asked by your child's health care provider to evaluate his/her bladder problems. Before we can determine what is causing your child's issues and begin a plan of treatment, we must have a voiding diary. This diary helps us understand your child's bladder function and helps us diagnose what is causing his/her problems. **Not completing the diary before the appointment will delay treating your child's problem.**

HOW TO OBTAIN A VOIDING DIARY

Step 1: Pick a day to start the diary. This should be a day when you and your child will be home all day.

- You will need something to measure the urine. You can use a large measuring cup (Wal-Mart/Dollar Stores are good places to find a measuring cup). Your child's pediatrician's office may have something to assist you with daily measuring.

Step 2: Place your child's name and date of birth on **every** page.

Step 3: Each time your child urinates (pees) you should write down the date, the time, the amount of urine in ounces or ml, and any comments you have (like wetting or pain with urinating). Include the times your child wet their clothes instead of urinating in the toilet.

- The diary should be kept for a full 24 hour time period, including any bedwetting.
- Every time your child urinates or tries to urinate should be written down.
- **DO NOT** remind your child to urinate when getting the diary. This should be a record of how your child urinates without any one telling her/him to go.

Step 4: Repeat the process 2 more days. These days do not need to be in a row. **For example:** you can do the diary on three Saturdays, or on two Saturdays and one Sunday.

Children's Hospital
Greenville Health System

Patient Name: _____ DOB: ____

VOIDING DIARY-EXAMPLE

Date	Time	AMOUNT	Comments
1-7-12	9:00am	4 oz.	Wet the bed
1-7-12	1:30pm	6 oz.	Damp underwear
1-7-12	2:30pm	2 oz.	Dry underwear
1-7-12	5:30pm	3 oz.	Said it hurt
1-7-12	9:00am	5 oz.	Damp underwear
1-10-12	8:30am	5 oz.	Dry overnight
1-10-12	11:30pm	7 oz.	Wet Underwear
1-10-12	4:30pm	9 oz	Rushed to bathroom
1-10-12	8:00pm	3 oz	Dry Underwear
1-14-12	9:30am	5 oz	Wet the bed
1-14-12	2:30pm	8 oz	Wet underwear
1-14-12	2:45pm	Drops	
1-14-12	3:30pm	Couldnt go	Soakes clothes after
1-14-12	6:00pm	5 oz	
1-14-12	8:00pm	7 oz	

Step 5: **Bring the completed diary to our office *before* the appointment or fax it to 864-241-9200.** If these options are not possible, you **MUST** bring the diary with you the day of the appointment.

We look forward to meeting you and your child. Please do not hesitate to call us with questions or for any help in obtaining the voiding diary. Our office number is 864-454-5135.

Pediatric Urology
200 Patewood Drive – Suite A115
Greenville, SC 29615

Children's Hospital
Greenville Health System

Patient Name: _____ DOB: _____

VOIDING DIARY

Date	Time	Amount	Comments

J. Lynn Teague, MD Regina Monroe, MD Carmen Quintero, CPNP Terri Dean CFNP
Pediatric Urology
200 Patewood Drive, Suite A115, Greenville, SC 29615
Phone: (864) 454-5135 Fax: (864) 241-9200

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