

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: _____