GHS UNIVERSITY MEDICAL CENTER **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

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*** ***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: _____

SS#: _____ *Month / Day / Complete Year*

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 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 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 Hospital System for services rendered. I will be responsible for any amount not covered by my insurance.

Signature of Patient/Guardian/Guarantor: _____ **Date:** _____

Revised: 9.16.11

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