

PATIENT INFORMATION (Please print)

Full Legal Name: Preferred Name: Date of Birth: SS#: Sex: Ethnicity: Primary Care Physician: Preferred Pharmacy Name: Phone Number: Marital Status: Race: Home Address: Mail to Address: County: Primary Phone: Secondary Phone: Preferred language: E-mail: Veteran: 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: Date of Birth: SS#: Home Address: Mail to Address: (if different):

EMERGENCY CONTACT (Pediatric Patients please list someone other than parent(s)/guardian)

Primary Contact Name: Primary Phone: Patient Relation to Emergency Contact: Secondary Phone: Secondary Contact Name: Primary Phone: Patient Relation to Emergency Contact: Secondary Phone:

SECTION I

Patient Employer: Work Phone: Ext: 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: Date of Birth: SS#: Home Address: 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: Date of Birth: SS#: Home Address: Primary Phone: Secondary Phone: Employer: Work Phone: Ext:

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: \_\_\_\_\_