**GREENVILLE HOSPITAL SYSTEM**
**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 ☐

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

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

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