PRISMA HEALTH®

Patient Information

(Please print)

Full Legal Name: _____ Preferred Name: _____
Last *First* *Middle*

Sex: ☐ Male ☐ Female

Date of Birth: _____ SS#: _____ Ethnicity: Hispanic/Latino ☐
Month/Day/Complete Year Non-Hispanic/Non-Latino ☐

Refuse/Decline ☐

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 ☐ Other ☐ Unknown

Home Address: _____ City: _____ State: _____ Zip: _____

Mail to Address: _____ City: _____ State: _____ Zip: _____

County: _____ Home Phone: ( ) _____ Cell Phone: ( ) _____

Preferred language: _____ E-mail: _____

Veteran: ___Yes ___No ___Unknown Religion: _____

Guarantor Information *(If guarantor is Self, skip to Emergency Contact)*
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*

Home Phone: ( ) _____

Date of Birth: _____ SS#: _____ Cell 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: _____ Home Phone: ( ) _____

Patient Relation to Emergency Contact _____ Cell Phone: ( ) _____

Secondary Contact Name: _____ Home Phone: ( ) _____

Patient Relation to Emergency Contact _____ Cell Phone: ( ) _____

Employment

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)

Home Phone: _____ Cell 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)

Home Phone: _____ Cell 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. And, skip to Authorization (below).**

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

Subscriber: This is the person who carries the insurance. If Subscriber is the Patient, skip to Insurance Co Name field.

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: _____ Home Phone:_____

Employer: _____ Work Phone: _____ Ext._____

Insurance Co. Name: _____ **Phone:** _____

Policy/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

SUBSCRIBER: This is the person who carries the insurance. If Subscriber is the Patient, skip to Insurance Co Name field.

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: _____ Home Phone:_____

Employer: _____ Work Phone: _____ Ext._____

Insurance Co. Name: _____ **Phone:** _____

Policy/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**

Authorization

I authorize medical evaluation & treatment, and release of information for insurance/medical purposes concerning my illness and treatment. I hereby authorize payment from my insurance company to the Prisma Health for services rendered. I will be responsible for any amount not covered by my insurance.

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