GREENVILLE HEALTH SYSTEM
UNIVERSITY MEDICAL GROUP

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

Signature of Patient/Guardian/Guarantor: ______________________ **Date:** ______________

Revised:3.21.13

Patient History Form

Chart # ___________

Name______________________________ Date________ Age ________

Medications (include vitamins and herbal products)

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

Allergies to medications ____

Past Medical History – please check if you have ever HAD the following in the PAST:

☐ Asthma	☐ Chicken pox	☐ High blood pressure	☐ Prostate disease
☐ Allergies/hay fever	☐ Depression	☐ Heartburn/reflux	☐ Seizures
☐ Anemia	☐ Diabetes	☐ Hepatitis	☐ Stroke/TIA
☐ Arthritis, where_________	☐ Emphysema	☐ HIV/AIDS	☐ Thyroid disease
☐ Back Pain	☐ Fibromyalgia	☐ Kidney stones	☐ Tuberculosis
☐ Blood clot	☐ Gout	☐ Mental illness	☐ Ulcers of stomach
☐ Broken bone/fracture	☐ Heart murmur	☐ Osteoporosis	☐ Varicose veins
☐ Cancer, type___________	☐ Heart Attack	☐ Pneumonia	

Explain checked disorders if needed. ____
____
____

For Women Only

1st day of Last Menstrual Period ________ Could you be pregnant? Yes/No

Number of pregnancies ____ Miscarriages or abortions ____ Live births ____

Date of last Pap Test _______ Have you ever had an abnormal pap test? Yes/No

Date of last Mammogram _______ Have you ever had an abnormal mammogram? Yes/No

Past Surgeries	Date		Date
☐ Appendix removed	____________	☐ Hernia Repair	____________
☐ C-section	____________	☐ Hysterectomy	____________
☐ Gall bladder removed	____________	☐ Tonsils Removed	____________

Please list any additional surgeries

___________________	____________	___________________	____________
___________________	____________	___________________	____________

Hospitalizations

Have you ever been hospitalized (*except for surgeries listed above*)? Yes/No

Date	Reason for Hospitalization
_________	____
_________	____
_________	____
_________	____

Family History

	Father	Mother	Children	Brother	Sister	Grandmother	Grandfather
Alcoholism	□	□	□	□	□	□	□
Asthma	□	□	□	□	□	□	□
Bleeding disorder	□	□	□	□	□	□	□
Cancer	□	□	□	□	□	□	□
Diabetes	□	□	□	□	□	□	□
Glaucoma	□	□	□	□	□	□	□
Heart disease	□	□	□	□	□	□	□
High blood pressure	□	□	□	□	□	□	□
Kidney disease	□	□	□	□	□	□	□
Mental illness	□	□	□	□	□	□	□
Migraine	□	□	□	□	□	□	□
Osteoporosis	□	□	□	□	□	□	□
Seizures	□	□	□	□	□	□	□
Stroke	□	□	□	□	□	□	□

Type of Cancer: ______________________

Any other illnesses? ______________________

Social History

How often do you exercise? ______________ What type? ______________________

Caffeine Use How many cups of coffee/tea/soda do you drink per day? ______________

Tobacco Use *please circle* never used cigarettes cigars chewing tobacco snuff

Date began using ______________ Quit date (if applicable) ______________ How many per day? ______________

Alcohol Use How many drinks per week? ______ Most number of drinks you have had at one time within the past year? ________

Illegal Drug Use Please list any drugs used. ______________________

Do you attend church regularly? Yes / No If Yes, where? ______________________

Review of Systems – Please check if you are *currently* having problems with the following.

Constitutional
- □ Fever/Chills
- □ Headaches
- □ Insomnia

Eyes
- □ Blurred vision
- □ Double vision
- □ Itchy/watery eyes

Ears, Nose, Throat
- □ Earache
- □ Decreased hearing
- □ Trouble swallowing
- □ Sinus problems
- □ Hoarseness

Allergic/Immunologic
- □ Hay fever
- □ Insect allergies
- □ Food allergies

Cardiovascular
- □ Chest pain
- □ Palpitations
- □ Varicose veins
- □ Swelling in feet

Respiratory
- □ Wheezing
- □ Chronic cough
- □ Shortness of breath

Gastrointestinal
- □ Abdominal pain
- □ Nausea/vomiting
- □ Indigestion/heartburn
- □ Diarrhea
- □ Constipation
- □ Blood in stools
- □ Black, tarry stools

Genitourinary
- □ Urinary frequency
- □ Painful urination
- □ Retaining urine
- □ Incontinence
- □ Sexual dysfunction

Musculoskeletal
- □ Joint pain
- □ Back pain
- □ Muscle aches

Skin
- □ Skin rash
- □ Itching
- □ Jaundice

Neurologic
- □ Tremors
- □ Dizziness/vertigo
- □ Numbness/tingling

Endocrine
- □ Excessive thirst
- □ Too hot/cold
- □ Fatigue

Hematologic
- □ Bleed/bruise easily
- □ Clot easily
- □ Frequent infections

Psychologic
- □ Depression
- □ Nerves
- □ Anxiety

For Women Only
- □ Periods too heavy
- □ Painful periods
- □ Irregular periods
- □ Vaginal discharge

Is there anything else you would like to discuss? ______________________

I certify that the above information is true to my knowledge.

Signed ______________________ Date ________

Reviewed by ______________________ Date ________

Consents/Registration
Greenville Health System

CONSENT AND AUTHORIZATION - UMG

The following are conditions for services provided by the Greenville Health System (GHS) for the above-named patient :
CONSENT AND AUTHORIZATION FOR ROUTINE TREATMENT: I consent to and authorize GHS and my health care providers to provide or order routine health care services, including diagnostic and laboratory procedures that in the judgment of my provider(s), are necessary. Unless otherwise discussed with me, I authorize GHS to dispose of specimens, tissues, medical devices, or implants removed from my body during my treatment. Diagnostic/laboratory procedures that may be ordered could include testing for HIV, Hepatitis, and other diseases categorized as sexually transmissible diseases. I can tell my provider if I do not want to be tested for any and all of these diseases. If test results are positive, they will be shared with me.
PHYSICIANS: I understand that physicians who are members of the GHS medical staff and who practice in GHS facilities may not be employees or agents of GHS. I understand that GHS is not responsible for any act or omission by a physician who is not an employee or agent of GHS. I understand GHS is a medical teaching institution and that students and residents may be involved in my care with required/appropriate supervision.
ASSIGNMENT OF INSURANCE BENEFITS AND THIRD PARTY CLAIMS: If my account is not paid at the time of my visit, I hereby assign to GHS any and all rights, including proceeds, I may have from the following: TRICARE major medical benefits, PIP (personal injury protection), sick benefits, physician benefits (excluding any benefits payable to physicians who are not employees or agents of GHS), injury benefits, or any other health, accident or welfare benefits of any type or form, whether insured or self funded, proceeds of any liability settlement or judgment being paid by or on behalf of a third party, or any other benefits due from the insurance policy. I also assign to physician(s) not employed by GHS, any proceeds of the foregoing benefits being paid by or on behalf of a third party or due from any insurance policy for services provided at GHS (such as anesthesiologists, pathologists, and other private physicians).I warrant and represent that any insurance or any plan which I assign is valid insurance and in effect and that I have the right to make this assignment. All amounts collected will be applied to my account. I understand that I am responsible for any charges not covered by insurance, including Medicare, Medicaid, or any other benefits. In the event a claim for payment submitted by GHS to my insurance carrier or plan administrator is denied, I hereby authorize GHS to seek an administrative review of the disputed claim in accordance with the applicable provision(s) of my plan or policy, appeal or file a legal/equitable action. If my plan or policy is provided pursuant to the Federal Employees Health Benefits Act, 5 U.S.C. §8901, et seq., this review process will include, but is not limited to, a review by the Office of Personnel Management. In the event I am a participant/beneficiary of an employee welfare benefit plan governed by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C §1001 et seq., I designate GHS as my authorized representative and grant to GHS the authority to act on my behalf in pursuing and appealing a benefit determination under the plan, including Medicare and Medicaid. Such authority shall include the right to request and receive a copy and/or summary of the plan description.
FINANCIAL AGREEMENT: I understand that I am obligated to pay my account according to the regular rates and terms of GHS, except for those services provided in accordance with a clinical research trial, which are specifically identified in writing as services for which I am not obligated to pay. I hereby appoint GHS as my representative to collect the claims, endorse the checks, and give full and final receipt for all amounts collected. If the benefits received by GHS exceed the charges on my account, I authorize GHS to apply the over-payment to my other outstanding account(s) with GHS or GHS entities, which include GHS Partners in Health, Inc., Greenville Health Corporation, and/or any other entity that is or becomes a part of GHS. If there is no other outstanding account for which I am responsible, the payment will be posted to the intended account and a refund processed accordingly. I understand that GHS may obtain my credit report for review in collection of this account. In the event that this account is placed with a collection agency or an attorney for collection, I will be responsible for paying all costs of collection, including attorney's fees.
MEDICARE PATIENTS: Should I be eligible for Medicare coverage, I request that payment of authorized Medicare benefits be made to GHS on my behalf. The information given by me is correct, in applying for payment under Title XVIII of the Social Security Act.
CONTACTING PATIENTS: I hereby authorize GHS to contact me through the information provided at the time of registration.
DISCLOSURE/USE OF HEALTH INFORMATION: I understand that uses and disclosures of my personal and health information are described in the GHS Notice of Privacy Practices. These include providing my information to other providers for my continuing care, to an insurance company or other payor (such as Medicare) to process payment for my care, and for GHS health care operations such as medical education, peer review and outcomes analysis activities. I understand that my personal and health information will be made available to providers through the GHS Health Information Exchange as described in the Notice of Privacy Practice. I acknowledge by signing below that I have received a copy of the GHS Notice of Privacy Practices.
PHOTOGRAPHING: I consent to GHS taking photographs for purposes of identification, diagnosis, treatment, education, and research. Photographs that could identify me will be used only for internal medical record identification purposes unless I specifically agree and sign an additional consent document.

CONDITIONS FOR CARE; ALTERATIONS VOID: I understand that the above are conditions for care and treatment at GHS. Any alterations to the content of any of the conditions above are void and will not change the conditions as stated. I understand that by signing this form, or receiving care or treatment at GHS, I agree to the contents of this Consent and Authorization in its "as is" form.

SIGNATURE OF PATIENT/LEGALLY AUTHORIZED REPRESENTATIVE ________________________________

PRINTED NAME AND RELATIONSHIP IF OTHER THAN PATIENT ________________________________

DATE __________ TIME _______________

SIGNATURE OF WITNESS _________________________ DATE ______________ TIME ____________________

SIGNATURE OF WITNESS _________________________ DATE ______________ TIME ____________________
(SECOND WITNESS FOR TELEPHONE CONSENT OR SIGNATURE WITH "X" OR MARK)

CHART COPY

Heritage Pediatrics and Internal Medicine-Simpsonville
727 S.E. Main Street, Suite 320
Simpsonville, SC 29681
Phone: (864)454-6440 Fax: (864)454-6445

GREENVILLE HEALTH SYSTEM

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

ONE PER REQUEST

Patient Full Name (PRINT)_______________________________ SS# ________________ DOB ________________

is requesting that the Greenville Health System University Medical Group practice identified above release health information (check one) ☐ **TO or obtain** ☐ **FROM the person/company/agency/facility listed below.**

Name, Position, or Department:	
Name of Organization:	
Address of Organization:	
Phone number of Organization:	

The information to be disclosed relates to service dates beginning _____________ and ending ______________

☐ Entire medical record	☐ Medication List	☐ Physical Therapy notes
☐ Demographic Information	☐ Immunizations	☐ Occupational Health Record
☐ History & Physical	☐ Test Results (lab, X-ray, etc.)	☐ Other: (specify)
☐ Medical/Surgical History	☐ Other Assessments	☐ Other: (specify)
☐ Physician Office Visits	☐ Discharge Summary	☐ Other: (specify)

The purpose of the disclosure: *("Request of the Individual" is sufficient for patient-initiated releases)*

☐ Request of Individual	☐ Change of Doctor	☐ Legal Investigation
☐ Referral to Specialist	☐ Insurance	☐ Other: (specify)
☐ Continuing Care	☐ Workers Comp	

CONDITIONS and NOTIFICATIONS:
This authorization for release of information expires 12 months from the date of patient's signature. You may revoke this authorization at any time by writing to the Office Supervisor at the address listed above. However, such notification will not affect any actions taken in reliance on this authorization prior to the time of receipt of the revocation. You may inspect or request a copy of the health information to be used or disclosed, consistent with federal law. This authorization is being given to the GHS UMG group practice identified above and to GHS and each practice and entity affiliated with it including GHS Partners in Health.
Note: There may be a processing fee charged to the patient to cover labor, copying, and supplies used to reproduce medical records.

SIGNATURES:
I hereby authorize the use or disclosure of the personal health information as described above. I understand that I may refuse to sign this authorization, that this authorization is voluntary and that my health care and the payment for my health care will not be affected if I do not sign this form. I also understand that if the individual or organization authorized to receive the information is not a health plan or health provider, the released information may no longer be protected by federal privacy regulations and, therefore, may be subject to re-disclosure.

Signature of Patient/Personal Representative: ____________________________________ Date: ______________

PRINT Name of Personal Representative: ____

Relationship of Representative to Patient: ____

Released by: ____ Date: ______________
(Department Representative Name)

****ADDITIONAL FORM REQUIRED FOR EACH PROVIDER****

Heritage Pediatrics and Internal Medicine-Simpsonville
727 S.E. Main Street, Suite 320
Simpsonville, SC 29681
Phone: (864)454-6440 Fax: (864)454-6445

GREENVILLE HEALTH SYSTEM

DISCLOSURE OF MEDICAL INFORMATION

Patient Full Name (PRINT) ____ DOB ______________________

Disclosure of Medical Information: Your medical information and communication of that information is essential to your care. We prefer to speak directly with each patient but we understand that other individuals or family members may have knowledge of and be assisting in your care. Please list the individuals who we are authorized to discuss your care with. (NOTE: We can not discuss your care with others, including spouses or other family members living with you, unless they are listed below.)

Name of Person	Relationship to Patient
______________________________	______________________
______________________________	______________________

Confidential Communication: Communication between this practice and you, the patient, is critical to your health. Please list the phone number(s) where we can reach you.

☐ Home: ________________________ ☐ Work: ____________________________

☐ Cell phone: ______________________ ☐ Other: ____________________________

If we are unsuccessful at reaching you at the above phone numbers, please list others who we can contact to get a message to you to call our office. *An automated appointment reminder system will call your home number listed in our data base.*

Name of Person	Phone Number	Relationship to Patient
__________________________	________________________	____________________
__________________________	________________________	____________________

Messages: A request for return calls may be left on the following answering machine or voice mail *(check all that apply)*

☐ At home ☐ At work ☐ On my cell phone ☐ I do not authorize

I authorize any medical information regarding myself to be left on the following answering machine or voice mail

(Check all that apply) ☐ At home ☐ At work ☐ On my cell phone ☐ I do not authorize

Signatures: I hereby authorize the use or disclosure of the personal health information as described above.

Patient/Personal Representative Signature: ___________________________________ Date: _____________

PRINT Name of Personal Representative: ____

Relationship of Representative to Patient: ____

GHS UMG Representative: ____Date: ____________

Note: This restriction applies only to care provided by the Greenville Health System University Medical Group practice identified in the upper left hand corner of this form. Other providers involved in your treatment may require you to complete a separate request for restriction. Either you or UMG may terminate this restriction by completing the following. **The below signature is to be used if you would like to make the above information terminate on a certain date.**

This agreement is terminated as of ____________ Signature ___________________________ *(Date)* ________

GREENVILLE
HEALTH SYSTEM

Greenville Health System
University Medical Group*

FINANCIAL POLICY

Please read this financial policy carefully. If you have any questions about this policy, any member of our staff will be glad to assist you.

The following are the conditions for services provided to the patient by Greenville Health System, GHS Partners in Health, and the various entities and providers affiliated with them each individually and collectively referred to as Greenville Health System University Medical Group or GHS UMG.

Payment for Service: Each office will inform you of co-pay and deductible amounts at check in or check out. These amounts are due at the time of service. As a courtesy to you, we will file your insurance claims if you provide us with a copy of your current insurance card. We require that you pay your deductible, co-payment, and/or any charges not covered by insurance.

Method of Payment: You may pay your bill with cash, personal check, certain credit cards, or debit card.

Returned Checks: A $25.00 service charge will be added on all checks returned to us for insufficient funds.

Non-appointment prescription refills: A $15.00 charge per incidence may be added for non-appointment prescription refills.

Non-appointment prescription: A $25.00 charge may be billed to you for new prescriptions filled via phone.

Completion of medical forms: There may be a charge for completion of forms such as disability, camp physicals, etc.

Copies of Medical Records: There may be a charge for completion of this process; SC Sec. 44-7-325 for Health Care Facilities

- $.65 per page for the first 30 pages
- $.50 per page for all other pages
- Clerical fee not to exceed $15.00
- Plus actual postage

No-show Appointments: A fee of $25.00 for a follow up visit and $50.00 for a new patient visit or endoscopy procedure may be charged for all missed appointments not cancelled at least 24 hours prior to the appointment time. You will be financially responsible for the fee, as insurance plans do not cover these charges. You may notify our office of any cancellations by calling during normal office hours.

Payment for Services Provided by Certain Non-UMG Providers: If you are having laboratory and/or diagnostic services by providers other than this office or other practices doing business as GHS University Medical Group, you may be billed separately by that service provider. This includes services provided by Greenville Health System.

Collection Policy: Delinquent accounts will be forwarded to a collection agency. We will inform you of your account status on your statement. If you are unable to pay your balance promptly, please call us at 864-454-2000 or 1-888-284-6024 to make payment arrangements. We will attempt to contact you by letter before your account is forwarded.

Questions: We are here to help should you have any questions regarding your statement or insurance.