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

GREENVILLE HEALTH SYSTEM

DATE:_____

HEALTH HISTORY QUESTIONNAIRE – NEW PATIENT

Questions contained in this questionnaire are strictly confidential & will become part of your medical record.
Please answer to the best of your ability. ***PLEASE COMPLETE FRONT & BACK OF PAGE***

Name: _____ Preferred Name: _____Date of Birth: _____

FOR OFFICE STAFF USE ONLY				
BP:	***PULSE:***	***TEMP:***	***WEIGHT:***	***HEIGHT:***

Reason for today's visit: _____ Onset/Date of Injury: _____

Pain Scale: *(circle one)* ☐ **NO PAIN**

0 1 2 3 4 5 6 7 8 9 10

Pain Description

☐ Aching ☐ Numb
☐ Burning ☐ Sharp
☐ Cramping ☐ Shooting
☐ Discomfort ☐ Other:_____
☐ Dull ☐ Other:_____

Pain Frequency

☐ Constant/Continuous
☐ Rarely
☐ Intermittent
☐ Other:_____

Pain Progression

☐ Not Changed
Gradually: ☐ Worsening ☐ Improving
Rapidly: ☐ Worsening ☐ Improving
☐ Resolved
☐ Other:_____

Level of Activity/Exercise:

On average, how many days a week of moderate to strenuous exercise (e.g. a brisk walk)? _____
On average, how many minutes do you exercise per day? _____
Total minutes of exercise per week: _____

Current Medications:

Name	*Strength*	*How Taking*

Allergies:

Name	*Reaction*

Preferred Pharmacy: _____ Phone: _____

Medical History *(check all that apply)*

☐ Cancer ☐ GERD ☐ Hypertension ☐ Stroke
☐ Clotting Disorder ☐ Heart Condition (specify): _____ ☐ Kidney Disease ☐ Blood Clot_____
☐ Diabetes Mellitus ☐ Hepatitis (specify A,B,C): _____ ☐ Osteoporosis/Osteopenia ☐ OTHER_____
☐ Emphysema ☐ HIV/AIDS Hypertension ☐ Parkinson's Disease ☐ OTHER_____

Surgical History

Type	*Date*	*Surgeon*

(OVER FOR PG 2)

Family History

Relationship	*Medical Condition(s)*
Mother:	
Father:	
Brother:	
Sister:	
Other (specify):	

☐ **Adopted**

☐ **Family History Unknown**

Social History

☐ **No History of Tobacco Use**
- ☐ Tobacco Use
  Type: _____
  Frequency: _____
  Duration: _____
  Quit Date: _____

☐ **I Do Not Drink Alcohol**
- ☐ Alcohol Use
  Type: _____
  _____ /Day
  _____/Week

☐ **No History of Drug Use**
- ☐ Drug Use
  Type: _____
  Frequency: _____
  Duration: _____
  Quit Date: _____

Review of Systems

Constitution
- ☐ **NONE**
- ☐ Appetite Loss
- ☐ Chills
- ☐ Diaphoresis (sweating)
- ☐ Fever
- ☐ Generalized Weakness
- ☐ Malaise/Fatigue
- ☐ Night Sweats
- ☐ Weight Gain
- ☐ Weight Loss

HENT
- ☐ **NONE**
- ☐ Congestion
- ☐ Headaches
- ☐ Hearing Loss
- ☐ Hoarseness
- ☐ Sinusitis

Gastrointestinal
- ☐ **NONE**
- ☐ Abdominal Pain
- ☐ Anorexia
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive Appetite
- ☐ GERD
- ☐ Liver Problems
- ☐ Nausea
- ☐ Vomiting

Eyes
- ☐ **NONE**
- ☐ Cataracts
- ☐ Vision Changes
- ☐ Vision Loss (LT / RT)

Cardiovascular
- ☐ **NONE**
- ☐ Chest Pain
- ☐ Claudication
- ☐ Irregular Heartbeats
- ☐ Leg Swelling due to cardiac condition
- ☐ Palpitations
- ☐ Poor Circulation
- ☐ Syncope

Genitourinary
- ☐ **NONE**
- ☐ Bladder Infection
- ☐ Dysuria (pain/difficulty with urination)
- ☐ Frequency
- ☐ Hematuria (blood in urine)

Respiratory
- ☐ **NONE**
- ☐ Asthma
- ☐ COPD
- ☐ Cough (persistent)
- ☐ Pneumonia
- ☐ Shortness of Breath
- ☐ Wheezing

Endocrine
- ☐ **NONE**
- ☐ Diabetes
- ☐ Hyperthyroid
- ☐ Hypothyroid
- ☐ Intolerance of Cold
- ☐ Intolerance of Heat

Heme/Lymph
- ☐ **NONE**
- ☐ Anemia
- ☐ Blood Transfusions
- ☐ DVT
- ☐ Easy Bruising/Bleeding

Neurological
- ☐ **NONE**
- ☐ Brief Paralysis
- ☐ Coordination Disturbance
- ☐ Daytime Sleepiness
- ☐ Dementia
- ☐ Dizziness
- ☐ Light-Headedness
- ☐ Loss of Balance
- ☐ Numbness
- ☐ Paresthesias
- ☐ Seizures
- ☐ Sensory Change
- ☐ Stroke/CVA/ITA
- ☐ Tremors
- ☐ Vertigo

Skin
- ☐ **NONE**
- ☐ Poor Wound Healing
- ☐ Rash
- ☐ Skin Cancer
- ☐ Skin Infection
- ☐ Ulcer/Open Sore

Musculoskeletal
- ☐ **NONE**
- ☐ Arthritis
- ☐ Back Pain
- ☐ Falls
- ☐ Gout
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Muscle Cramps
- ☐ Muscle Weakness
- ☐ Myalgias (muscle pain)
- ☐ Neck Pain
- ☐ Pain in Multiple Joints
- ☐ Stiffness

Psychiatric
- ☐ **NONE**
- ☐ Bipolar Disorder
- ☐ Depression
- ☐ Nervous/Anxious

Aller/Immuno
- ☐ **NONE**
- ☐ Environmental Allergies
- ☐ Food Allergies: _____
- ☐ HIV Exposure
- ☐ Hives
- ☐ Iodine
- ☐ Persistent Infections

Name: **DOB:**

PAIN AND PROBLEM QUESTIONNAIRE

DATE _____

What is the main reason for your office visit today (chief complaint): ☐ Right ☐ Left

Have you had any of the following (pertaining to this problem)? ☐ MRI ☐ X-rays ☐ CT ☐ Other _____

When did your symptoms first appear? _____
How long has this problem been present? _____Days _____Weeks _____Months _____Years

How did this begin: ☐ Gradual ☐ Suddenly ☐ After Injury ☐ No Known Mechanism of Injury
☐ Work-Related ☐ Work-Injury ☐ Motor Vehicle Crash

Please provide date of injury or accident:_____
Describe injury or accident:_____
_____

Circle the number that describes your pain **right now**? (for the specific problem you are being seen for today)

No pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

My pain is ☐ Not satisfactorily controlled ☐ Satisfactorily controlled

The pain feels (quality): ☐ Sharp ☐ Stabbing ☐ Dull ☐ Aching ☐ Burning ☐ Throbbing
☐ Other:

The pain is (duration): ☐ Constant ☐ Comes and Goes (Intermittent)

Does your pain move anywhere? ☐ No ☐ Yes; where?

Are there any associated symptoms? ☐ Swelling ☐ Numbness ☐ Tingling ☐ Weakness ☐ Stiffness
☐ Locking ☐ Catching ☐ Giving Away ☐ Other:

Since your problem started, it is: ☐ Getting Better ☐ Getting Worse ☐ Unchanged

What makes your symptoms better? ☐ Rest ☐ Heat ☐ Ice ☐ Elevation ☐ Medication (see below)
☐ Other:

What makes your symptoms worse? ☐ Activity ☐ Exercise ☐ Work ☐ Kneeling ☐ Bending ☐ Squatting
☐ Stooping ☐ Stairs ☐ Hills ☐ Running ☐ Walking ☐ Prolonged Sitting ☐ Other:

Does your pain or problem interfere with any of the following (check all that apply): ☐ General Activity ☐ Sports ☐ Normal Work ☐ Mood ☐ Enjoyment of life ☐ Ability to concentrate ☐ Relationship with others
☐ Other (Explain):

Please check if you are having any of the following?
☐ Fever/chills ☐ Unexpected Weight Loss ☐ Rashes ☐ Night pain ☐ Recent Trauma
☐ Problems with bowel or bladder function ☐ Groin Numbness ☐ Recent bacterial infection
☐ Suppressed Immune System ☐ Intravenous drug use ☐ Pain with coughing or sneezing

Please answer the following questions if you are a post-menopausal woman or a man over age 65.

1. Have you ever had a bone density test?	☐ Yes	☐ No
2. Has someone in your family ever broken a hip or been told they have osteoporosis?	☐ Yes	☐ No
3. Is your diet low in calcium (avoid milk, cheese, yogurt, lactose intolerant)?	☐ Yes	☐ No
4. Do you have frequent/chronic diarrhea (gluten intolerance, malabsorption)?	☐ Yes	☐ No
5. Do you weigh less than 125 pounds?	☐ Yes	☐ No
6. Have you fallen down 2 or more times in the last year?	☐ Yes	☐ No
7. Do you have rheumatoid arthritis?	☐ Yes	☐ No
8. Have you taken steroids (Cortisone, Prednisone) for 3 or more months in your life?	☐ Yes	☐ No
9. Have you been treated for cancer with chemotherapy or other medication?	☐ Yes	☐ No
10. Do you take medication for epilepsy or a seizure disorder?	☐ Yes	☐ No
11. Do you currently smoke?	☐ Yes	☐ No
12. Do you drink 3 or more alcoholic drinks per day?	☐ Yes	☐ No
13. Do you drink 3 or more caffeinated drinks (coffee, tea, soda) per day?	☐ Yes	☐ No
14. Have you broken any bones (after the age of 50)?	☐ Yes	☐ No
15. Do you walk or jog for exercise?	☐ Yes	☐ No

Physician's Initial: _____ Date: _____

GREENVILLE HEALTH SYSTEM

THE INFORMATION PROVIDED IN THIS FORM WILL BE RELIED UPON BY ALL HEALTH CARE PROVIDERS OF GREENVILLE HEALTH SYSTEM UNLESS REVOKED OR MODIFIED BY THE PATIENT IN WRITING.

AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

Patient Full Name (PRINT) _____MRN _____ DOB _____

Authorization for Disclosure of Medical Information: The privacy of your medical information is important. We will discuss your medical condition with person(s) you designate.

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM? *(Check and complete one)*

☐ The following family members or other individuals may receive information regarding my medical condition:
Print first and last name(s) _____
_____

OR

☐ Any family member or other individual inquiring about my medical condition may receive information from my provider, EXCEPT the following individuals: *Print first and last name(s)* _____
_____

You may revoke/cancel or modify/change the above designation, but the revocation or modification must be in writing.

NOTE: This designation does not give the above named individuals the right to make health care decisions for you. If at any time you are unable to consent to care or treatment, we will follow the procedure set forth in the South Carolina Adult Health Care Consent Act.

Confidential Communication: Please provide phone number(s) where we can reach you:

☐ Home: _____ ☐ Work: _____ ☐ Cell phone: _____ ☐ Other_____

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

☐ Home ☐ Work ☐ Cell Phone ☐ I do not authorize

I authorize my medical information to be left on the following answering machine or voice mail: *(Check all that apply)*

☐ Home ☐ Work ☐ Cell Phone ☐ I do not authorize

If we are unable to reach you or leave a message at the above phone number(s), please indicate with whom we may leave a message for you to call our facility.

Name _____ Phone Number _____

Name_____ Phone Number _____

Note: *An automated appointment reminder system may call the number listed in our data base.*

Signature: I hereby authorize the disclosure of my medical condition and information as described above.

Patient/Patient's Representative Signature: _____ Date: _____Time:_____

PRINT Name (if Patient's Representative): _____

Relationship to Patient (if Patient's Representative):_____

GHS Representative: _____Date: _____Time:_____

Form Create Date: December 30, 2013

GREENVILLE HEALTH SYSTEM

Orthopaedic Surgery and Sports Medicine Fellowship Program

Information and Disclosure Statement

During your visit today you may be examined by a physician who is participating in the Steadman Hawkins Clinic of the Carolinas Fellowship Program. Fellowship programs are accredited, one year fellowships in which fully trained orthopaedic surgeons and primary care physicians are chosen from the top medical schools and residency programs across the country to do an additional year of study to focus on shoulder and knee reconstruction and sports medicine. Annually, a group of six physicians is chosen from over 100 applicants to participate in the Orthopaedic Surgery Fellowship Program and two physicians for the Primary Care Sports Medicine Fellowship.

If a Fellow is caring for you, he will introduce himself and state that he will be working closely with the consulting doctor in your ongoing care. A plan of treatment is suggested by the Fellow and finalized by the supervising surgeon or physician. In the operating room, before your surgery, the Fellow will meet with you, along with the consulting surgeon. The Fellow may participate in the surgical procedure in the operating room. After surgery, the Fellow, along with the consulting surgeon, will see you on rounds.

A Fellow's role in surgery is under the direct supervision of one of our surgeons who is present during all cases. All patient interaction is under close supervision of the Steadman Hawkins Clinic physicians. Steadman Hawkins Clinic is also part of the Greenville Health System Orthopaedic Residency Program. Residents are medical doctors in training to become orthopaedic surgeons. They may be involved in your care as well and will perform his/her role under supervision of the Steadman Hawkins Clinic physician.

Having trained over 150 surgeons world-wide, we are proud of our fellowship program. It is one of the best in the country and the only ACGME Accredited Orthopaedic Sports Medicine Fellowship in South Carolina. It is important for our patients and the community to know that our fellowship and residency programs, along with the Steadman Hawkins Clinic physicians provide a large talented team to deliver to you the best possible medical care.

Please feel free to ask the Fellow or the consulting physician any questions you might have regarding the Steadman Hawkins Clinic of the Carolinas Fellowship Programs.

Patient Signature	Date of Birth	Date

Patient's Printed Name

GREENVILLE HEALTH SYSTEM
Steadman Hawkins Clinic of the Carolinas

HAWKINS FOUNDATION

Orthopaedic Surgery and Sports Medicine Fellowship Program Disclosure Statement

During your visit today you may be examined by a physician who is participating in the Steadman Hawkins Clinic of the Carolinas Fellowship Program. We have both an Orthopaedic Sports Medicine Fellowship Program and a Nonoperative/Primary Care Sports Medicine Fellowship Program. The programs are accredited one year fellowships in which fully trained orthopaedic surgeons and primary care physicians are chosen from the top medical schools and residency programs across the country to do an additional year of study to focus on shoulder and knee reconstruction and sports medicine. Annually, a group of six physicians are chosen from over 100 applicants to participate in the Orthopaedic Surgery Fellowship Program and two physicians for the Primary Care Sports Medicine Fellowship.

In working with patients, the Fellows will introduce themselves and state that they will be working closely with the consulting doctor in your ongoing care. A plan of treatment is suggested by the Fellow and finalized by the supervising surgeon or physician. In the operating room the fellow will meet with the patient along with the consulting surgeon preoperatively, see patients after surgery with the consulting surgeon on rounds, and may participate in surgical procedures in the operating room.

A Fellow's role in surgery is under the direct supervision of one of our surgeons who is present at all cases. All patient interaction is done under close supervision of the Steadman Hawkins Clinic physicians. We are also part of the Greenville Health System Orthopaedic Residency Program. Residents are medical doctors in training to become orthopaedic surgeons. They may be involved in your care as well and will perform his/her role under supervision.

Having trained over 150 surgeons world wide, we are proud of our fellowship program. It is one of the best in the country and the only ACGME Accredited Orthopaedic Sports Medicine Fellowship in South Carolina. It is important for our patients and the community to know that this situation provides the best possible medical care for you with a large talented team involved in your care.

Please feel free to ask the Fellow or the consulting physician any questions you might have regarding the Steadman Hawkins Clinic of the Carolinas Fellowship Programs.

_____	_____	_____
Patient Signature	Date of Birth	Date