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:** _____

Revised:10.19.11

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

UPSTATE MEDICAL REHABILITATION

Name: _____ DOB: _____ SS# _____

Who referred you to our office? _____

Reason for visit: _____ When did it start? _____

Is this problem work related? [ ] Yes [ ] No

Did you symptoms begin…. [ ] suddenly [ ] gradually

How long have you had these symptoms? [ ] days [ ] weeks [ ] months [ ] years

Have you been evaluated by other doctors for this problem? [ ] yes [ ] no

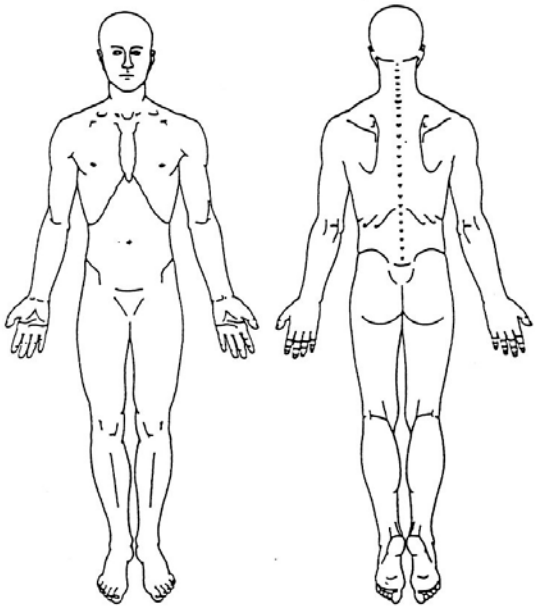
If yes, by whom? _____ When? _____

Please circle the level of pain that is roughly equal to your average pain level *without medication*.

1 2 3 4 5 6 7 8 9 10 (0 = no pain and 10 being the most severe pain imaginable)

Circle the level of pain that is roughly equal to your average pain level *with medications*.

1 2 3 4 5 6 7 8 9 10 (0 = no pain and 10 being the most severe pain imaginable)



Previous Treatments for **this problem only**:

☐Physical Therapy ☐Chiropractic Treatment

☐ Trigger Point Injection ☐ Epidural

☐ Facet Injection ☐Nerve Block ☐ TENS Unit

☐ Sacroiliac Joint Injection

☐Medications: (list) _____

_____

Review of systems: (Circle all that apply)

General: unexpected weight loss, weight gain, fevers, chills, fatigue, decreased appetite, headaches

Eyes: glaucoma, cataracts, eye surgery, blindness, eye pain, blurry vision, decreased vision

Ear/Nose/Throat: hearing loss, hearing aids, sinus infection(s), dentures, thyroid enlargement

Cardiovascular: chest pain, heart disease, heart attack, palpitations, abnormal heart rhythm, heart murmur, prosthetic heart valve, Coumadin, Anticoagulation, aneurysm

Pulmonary: shortness of breath, COPD, asthma, emphysema, sleep apnea, coughing

Gastrointestinal: vomiting, nausea, constipation, acid reflux, heartburn, stomach ulcers, diarrhea, blood in stool, black tarry stool

Urinary: incontinence, bladder urgency, bladder infection, kidney infection, kidney stones, blood in urine

Endocrine (Hormones): diabetes, thyroid disease, menopause, hot flashes

MS: joint pain (Which?_____), muscle pain, recent broken bones or injury, swelling

Skin: cancer (if yes, type? _____), rash, cellulitis, infections

Neurologic: history of stroke (CVA), dizziness, fainting/syncope, tingling, numbness, memory problems, headaches, poor balance, dizziness/vertigo, spasticity, spinal cord injury, cerebral palsy, brain injury

Hem/Lymph: anemia, bleeding disorder, leukemia, adema/swelling in legs, lymphedema

Immunologic: HIV, AIDS, hepatitis, sexually transmitted disease, shingles

Psychological: depressions, anxiety, suicidal thoughts, suicidal attempts in past, bipolar disorder (manic depressive), personality disorder, recent counseling, psychiatric hospitalization in past

Past Medical History: (check all that apply to you) [ ] None

- ☐ High blood pressure
- ☐ Bleeding disorder
- ☐ Anemia
- ☐ Kidney (renal) problems
- ☐ History of stomach bleeding?
- ☐ Rheumatoid Arthritis? (Which joints)
- ☐ Thyroid Disease (Hypo/Hyper)
- ☐ Abnormal heart rhythm
- ☐ Diabetes
- ☐ Sleep disorder
- ☐ Reflux
- ☐ Stomach ulcers
- ☐ High cholesterol
- ☐ Hepatitis A,B, C
- ☐ Seizures
- ☐ Sleep apnea
- ☐ Osteoarthritis? (Which joints?
- ☐ Cancer (type?)
- ☐ Alcoholism, now or in the past
- ☐ Drug abuse or addiction
- ☐ Heart disease
- ☐ Depression
- ☐ Blood clots
- ☐ Obesity
- ☐ Heart attack
- ☐ Anxiety
- ☐ Osteoporosis
- ☐ Fractures

Female Patients: Is there any chance at all that you could be ☐ Yes ☐ No pregnant?

Past Surgical History: Check all that apply to you [ ] No Surgeries

- ☐ Appendectomy
- ☐ Tonsillectomy
- ☐ Gallbladder surgery
- ☐ Eye surgery
- ☐ Hip surgery for fracture (left/right/both)
- ☐ Hip replacement (left/right/both)
- ☐ Coronary bypass (when?
- ☐ Knee Arthroscopy (left/right/both)
- ☐ Knee replacement (left/right/both)
- ☐ Foot/ankle surgery
- ☐ Carpel tunnel surgery (left/right/both)
- ☐ Hysterectomy (partial/complete)
- ☐ Cervical fusion When? _____ By Doctor: _____
- ☐ Lumbar Laminectomy or Discectomy When? _____ By Doctor: _____
- ☐ Lumbar spinal fusion When? _____ By Doctor: _____
- ☐ Other Surgeries (Please List)

Medications: (Please list all of your current medications. BRING THEM TO YOUR FIRST APPOINTMENT)

[ ] **I take no medications currently**

Medications	Dosage (#mg)	How many per day

List any medication allergies: _____

_____

Check if you have an allergy to: [ ] Latex (such as "rubber" gloves) [ ] Contrast Dye

List any Medication adverse reactions: _____

Family Medical History (Mom, Dad, Siblings, Grandparents):

[ ] No significant family history [ ] Non-Contributory

[ ] Heart Disease: Who _____ [ ] High Blood Pressure: Who _____

[ ] Diabetes: Who _____ [ ] Cancer: Type _____ Who _____

[ ] Stroke: Who _____

Social History

Marital Status: □ Single □ Married □ Divorced □ Separated □ Widowed

Education: (highest level achieved) □ Grade School □ High School □ College/University □Grad School

Tobacco Use: □ Yes □ No Type:_____ Per day_____ Years in total?_____ Date Quit_____

Alcohol Use: □ Yes □ No Type:_____ Frequency _____ Alcoholic Date Quit _____

Drug Use in past or present: □ Yes □ No Type:_____ Frequency _____ Date Quit _____

Exercise: □Walking □ Running □ Biking □ Swimming □ Gym Workouts

How far can you walk before you have to rest? □ < 50 feet □_____ block(s) □____miles □ unlimited

Work Status

□ Currently Working □ Employed, but not currently working □ Unemployed

I am working: □ Full Time □ Part Time

Duty Status: □ Full Duty □ Light Duty □ Modified Duty

Litigation:

Do you have an attorney handling this matter? □ Yes □ No

Is there a pending lawsuit or other litigation regarding this matter? □ Yes □No

Who do you see for your general medical care? (Your primary medical doctor?)

Full MD Name:_____

Practice Name: _____

Address: _____

Phone: _____

Patient Signature: _____ Date: _____