



**GREENVILLE
HEALTH SYSTEM**

Blue Ridge Women's Center

103 Carter Park Drive, Suite A
Seneca, SC 29681
(864) 482-2360 P
(864) 482-2365 F
ghs.org

Martin Allen, MD
Vance Pirkle, MD
Randall Royal, MD
Christina Schwering, MD
Anne Hammond-Perrin, CNM

Thank you for choosing Blue Ridge Women's Center for all of your obstetric and gynecological needs. Our knowledgeable and experienced physicians are devoted to providing high quality and compassionate OB/GYN care to upstate South Carolina and the Western Region of Greenville Health System. We pride ourselves in developing long-lasting, trusting relationships with our patients and their families.

There are a few things that will help us make your first visit here enjoyable and efficient. Please bring your insurance card, photo ID, and completed paper work with you to your appointment. We want to ensure that we have the most accurate information on file to make your visit successful from beginning to end. You will be expected to pay your copay or coinsurance at the time you receive services. If you do not have insurance, payment is expected at the time you receive services. Please ask our staff about our uninsured discount form that will need to be completed at check-in.

To ensure the most time with your physician, please arrive at least 15 minutes prior to your appointment time to allow us to complete your registration. Our office requires 24 hour notice for all cancelled appointment. There will be a fee for missed appointments that were not cancelled in a timely manner. Our practice is open Monday through Friday, 8:00 am to 5:00 pm.

We look forward to you joining our practice as a patient at Blue Ridge Women's Center. It is our promise to provide whole person care to you during this season of your life.

Thank you and welcome to our practice!

Blue Ridge Women's Center Staff



Patient Information

(Please print)

Full Legal Name: Last First Middle Preferred Name: Sex: Male Female Ethnicity: Hispanic/Latino Non-Hispanic/Non-Latino Refuse/Decline

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: 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: Last First Middle Patient relation to Guarantor: Home Phone: Cell Phone: Date of Birth: SS#: 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: Cell Phone: Patient Relation to Emergency Contact Secondary Contact Name: Home Phone: Cell Phone: Patient Relation to Emergency Contact

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: Last First Middle Nickname: Date of Birth: SS#: Home Address: City: State: Zip: 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: Last First Middle Nickname: Date of Birth: SS#: Home Address: City: State: Zip: 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

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

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



OB/GYN History Form

Name: _____ Date of Birth: _____ Date/Time: _____

Reason for Visit: _____

OB/GYN History

Date of last menstrual period: _____

Age at first period: _____

Frequency of period: _____

Days of flow: _____

Number of pads/tampons used on heaviest day: _____

Pain or cramps: Y N

Do you ever miss school/work because of your period: Y N

Sexually active: Y N

Method of birth control: _____

Abnormal Paps : Y N

New or changing lump in the breast : Y N

Deliveries

Number of times pregnant: _____

Number of miscarriages/abortions: _____

DATE	WEEKS	WT OF BABY	TYPE DELIVERY	COMPLICATIONS

Medications, Allergies and Immunizations

Today's Date _____ Patient Name _____ DOB _____

Please Bring All Medications to Your Visit
Prescription Medications -List all medications you are presently taking

Name and Dose	Prescribed by:	How Often	Date Started
1	_____	_____	_____
2	_____	_____	_____
3	_____	_____	_____
4	_____	_____	_____
5	_____	_____	_____
6	_____	_____	_____
7	_____	_____	_____
8	_____	_____	_____
9	_____	_____	_____
10	_____	_____	_____
11	_____	_____	_____
12	_____	_____	_____

Non-Prescription Medications -List all medications you are presently taking

Name and Dose	How Often	Date Started
1	_____	_____
2	_____	_____
3	_____	_____
4	_____	_____
5	_____	_____
6	_____	_____
7	_____	_____
8	_____	_____
9	_____	_____
10	_____	_____
11	_____	_____
12	_____	_____

Current Pharmacy

Name and Location _____ Phone Number _____

Preferred _____

Other _____

Today's Date _____ Patient Name _____ DOB _____

Allergies - list all allergies or unusual reactions you have to medications, foods, dyes latex and other agents.

Allergy	Reaction
1 _____	_____
2 _____	_____
3 _____	_____
4 _____	_____

List any reactions to bug bites or stings _____

Adult Immunizations - Check the box next to or list all immunizations received including the most recent date received.

	Date Received	Others	Date Received
<input type="checkbox"/> Tetanus	_____	_____	_____
<input type="checkbox"/> Flu	_____	_____	_____
<input type="checkbox"/> Pneumonia	_____	_____	_____
<input type="checkbox"/> HPV	_____	_____	_____
<input type="checkbox"/> Hepatitis B	_____	_____	_____

Screenings - List the most recent date and doctor for the following screenings:

	Date	Doctor/Practice/Facility Name
Complete Medical Physical	_____	_____
Full panel of lab work	_____	_____
Cholesterol (lipid) screening	_____	_____
Chest X-ray	_____	_____
Treadmill Stress Test	_____	_____
Other heart tests	_____	_____
Colonoscopy	_____	_____
Mammogram	_____	_____
Bone Density	_____	_____
	_____	_____
	_____	_____
	_____	_____



Today's Date _____ Patient Name _____ DOB _____

Hospitalization & Surgical History - List all hospital admissions and operations you have had.

Reason for Hospitalization/Surgery	Year
1 _____	_____
2 _____	_____
3 _____	_____
4 _____	_____
5 _____	_____
6 _____	_____
7 _____	_____
8 _____	_____
9 _____	_____
10 _____	_____

Yes No Did you have any problems with anesthesia? If yes, please describe.

Social History

Yes No Do you currently smoke or use other tobacco products? If yes, how many per day? _____

Yes No Have you smoked or used other tobacco products in the past? If yes, how many per day? _____

How many years since you last smoked? _____

Yes No Do you drink caffeinated beverages? If yes, what type, how often, how much? _____

Yes No Do you drink alcohol? If yes, what type, how often, how much? _____

Yes No Do you exercise regularly? If yes, what type? _____

How often and how long? _____

Family Medical History - Check the box next to any medical condition below that has affected any of your immediate family members (parents, brothers, sisters), state your relationship and their age at onset.

	Relationship	Age at onset
<input type="checkbox"/> High Blood Pressure	_____	_____
<input type="checkbox"/> High Cholesterol	_____	_____
<input type="checkbox"/> Heart Disease	_____	_____
<input type="checkbox"/> Stroke	_____	_____
<input type="checkbox"/> Migraines	_____	_____
<input type="checkbox"/> Seizures/Convulsions	_____	_____
<input type="checkbox"/> Diabetes	_____	_____
<input type="checkbox"/> Bleeding/Blood-clotting Disorder	_____	_____
<input type="checkbox"/> Allergies	_____	_____
<input type="checkbox"/> Asthma	_____	_____
<input type="checkbox"/> Thyroid Problems	_____	_____
<input type="checkbox"/> Osteoporosis	_____	_____
<input type="checkbox"/> Psychiatric Disorder/Mental Illness	_____	_____
<input type="checkbox"/> Alzheimer's/Dementia	_____	_____
<input type="checkbox"/> Cancer - type:	_____	_____
<input type="checkbox"/> Other:	_____	_____



AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

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.

Patient Name (PRINT) _____

(For Office Use Only)

DOB _____

MRN _____

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

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 or GHS.

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 \$25.00
- 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 canceled 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 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.