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__________

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
- ☐ Burning
- ☐ Cramping
- ☐ Discomfort
- ☐ Dull
- ☐ Numb
- ☐ Sharp
- ☐ Shooting
- ☐ Other:_______________
- ☐ 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
- ☐ Clotting Disorder
- ☐ Diabetes Mellitus
- ☐ Emphysema
- ☐ GERD
- ☐ Heart Condition (specify): ___________
- ☐ Hepatitis (specify A,B,C): ___________
- ☐ HIV/AIDS Hypertension
- ☐ Hypertension
- ☐ Kidney Disease
- ☐ Osteoporosis/Osteopenia
- ☐ Parkinson's Disease
- ☐ Stroke
- ☐ Blood Clot________________
- ☐ OTHER__________________
- ☐ 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

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