PRISMA HEALTH®

Patient Information

(please print)
Full legal name: _____ Preferred name: _____
Last *First* *Middle*

Date of birth: _____ SS#: _____
Month/Day/Complete year

Sex at birth: ☐ Male ☐ Female ☐ Intersex

Gender identity: ☐ Man ☐ Woman ☐ Transwoman ☐ Transman ☐ Nonbinary ☐ Another unlisted

What are your pronouns? ☐ He/Him ☐ She/Her ☐ They/Them ☐ Another _____

Primary care physician: _____

Preferred pharmacy name: _____ Phone number: _____

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Life partner ☐ Legally separated

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Refused/Decline

Race: ☐ Caucasian (white) ☐ American Indian ☐ African American (Black) ☐ Hispanic ☐ Biracial ☐ Asian ☐ Other ☐ Unknown

Home address: _____ City: _____ State: _____ ZIP: _____

Mail to address: _____ City: _____ State: _____ ZIP: _____

County: _____ Home phone: ( ) _____ Cellphone: ( ) _____

Preferred language: _____ Email: _____

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: _____ Patient relation to guarantor: _____
Last *First* *Middle*

Home phone: ( ) _____

Date of birth: _____ SS#: _____ Cellphone: ( ) _____

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: _____ Home phone: ( ) _____

Patient relation to emergency contact: _____ Cellphone: ( ) _____

Secondary contact name: _____ Home phone: ( ) _____

Patient relation to emergency contact: _____ Cellphone: ( ) _____

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 are 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)

Home phone: _____ Cellphone: ( ) _____

Employer: _____ Work phone: ( ) _____ Ext: _____

Father *(If the address, phone numbers and employer information are 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)

Home phone: _____ Cellphone: ( ) _____

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. 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 and treatment, and release of information for insurance/medical purposes concerning my illness and treatment. I hereby authorize payment from my insurance company to Prisma Health for services rendered. I will be responsible for any amount not covered by my insurance.

Signature of patient/guardian/guarantor: _____ **Date:** _____

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Authorization for Disclosure of Medical Information

Patient Full Name (PRINT) _____ 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)*

☐ **YES -** The provider may discuss my medical condition with the following family member or other individual:

_____

_____

☐ **NO** The provider may not discuss my medical condition with any family member or other individual.

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.

Communication: Please provide phone number(s) where we can reach you (by providing a number you also authorize Prisma Health to leave you voicemails at the number(s) listed):

☐ Home: _____ ☐ Cell: _____ ☐ Work: _____

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

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

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

PRINT Name (if Patient's Representative): _____

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

Prisma Health Representative: _____Date: _____Time:____

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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
❑ High Blood Pressure		
❑ High Cholesterol		
❑ Heart Disease		
❑ Stroke		
❑ Migraines		
❑ Seizures/Convulsions		
❑ Diabetes		
❑ Bleeding/Blood-clotting Disorder		
❑ Allergies		
❑ Asthma		
❑ Thyroid Problems		
❑ Osteoporosis		
❑ Psychiatric Disorder/Mental Illness		
❑ Alzheimer's/Dementia		
❑ Cancer - type:		
❑ Other:		

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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 _____

PRISMA HEALTH®

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 _____

Sexual Activity

Are you sexually active? ❑ Yes ❑ No

If you are sexually active, is your partner ❑ Male or ❑ Female?

Do you use birth control? ❑ Yes ❑ No If yes, what method? _____

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

		Date Received	Others	Date Received
❑	Tetanus			
❑	Flu			
❑	Pneumonia			
❑	HPV			
❑	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		