PRISMA HEALTH®

Patient Information

(Please print)

Full Legal Name: ____________________ Preferred Name: ____________
Last First Middle

Sex: ☐ Male ☐ Female

Date of Birth: ____________ SS#: ____________
Month/Day/Complete Year

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

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 ☐ 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: ____________________ Patient relation to Guarantor: ____________
Last First Middle

Home Phone: ( ) ____________

Date of Birth: ____________ SS#: ____________ Cell 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: ____________________ Home Phone: ( ) ____________

Patient Relation to Emergency Contact ____________________ Cell Phone: ( ) ____________

Secondary Contact Name: ____________________ Home Phone: ( ) ____________

Patient Relation to Emergency Contact ____________________ Cell Phone: ( ) ____________

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: ____________________ Nickname: ____________
Last First Middle

Date of Birth: ____________
Month / Day / Complete Year

SS#: ____________

Home Address: ____________ City: ________ State: ______ Zip: ______
(if different from patient)

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: ____________________ Nickname: ____________
Last First Middle

Date of Birth: ____________
Month / Day / Complete Year

SS#: ____________

Home Address: ____________ City: ________ State: ______ Zip: ______
(if different from patient)

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

Signature of Patient/Guardian/Guarantor: ____________ **Date:** ____________