

Patient Name: _____

DOB: _____

GHS UNIVERSITY MEDICAL GROUP

BILLING INFORMATION

ACCIDENTAL INJURY

Is visit result of an accident? (Examples: auto accident, workers compensation, etc.) YES / NO Date: _____

GUARANTOR INFORMATION (This is the person responsible for the balance after insurance pays on the account.)

Parent/guardian presenting minor child for treatment will be listed as the guarantor. This person will be responsible for any balances due after insurance has paid. If 18 or older, you are your own guarantor and do not have to complete this section unless there is a legal designation for your care, such as a power of attorney.

*******IF SELF DO NOT COMPLETE THIS SECTION BELOW*******

Guarantor Name: _____ Guarantor SS#: _____
(Last First Middle)

Relationship: _____ Primary Phone: (____) _____

Address: _____ Alternate Phone: (____) _____

City, State, Zip: _____

PO Box: _____ (Required if applicable)

City, State, Zip: _____

Guarantor Employer: _____ Work Phone: _____

PRIMARY INSURANCE INFORMATION

If SELF check this box

Insurance Co. Name: _____

ID#: _____ Effective Date: _____

Patient Employment Status: _____
(full-time, part-time, unemployed, retired, military, retired military, full or part-time student)

SUBSCRIBER INFORMATION (This is the person insured by the insurance company listed above.)

*******IF SELF DO NOT COMPLETE THIS SECTION BELOW*******

Patient Relationship to Subscriber: _____

Subscriber's Full Name: _____ Sex: _____ Date of Birth: _____
M or F

Address: _____ SS#: _____

City, State, Zip: _____ Phone: (____) _____

Employer: _____ Work Phone: (____) _____

SECONDARY INSURANCE INFORMATION

Insurance Co. Name: _____

ID#: _____ Effective Date: _____

Patient Employment Status: _____
(full-time, part-time, unemployed, retired, military, retired military, full or part-time student)

SUBSCRIBER INFORMATION (This is the person insured by the insurance company listed above.)

*******IF SELF DO NOT COMPLETE THIS SECTION BELOW*******

Patient Relationship to Subscriber: _____

Subscriber's Full Name: _____ Sex: _____ Date of Birth: _____
M or F

Address: _____ SS#: _____

City, State, Zip: _____ Phone: (____) _____

Employer: _____ Work Phone: (____) _____

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, University Medical Group for services rendered. I will be responsible for any amount not covered by my insurance.

Signature of Patient/Guardian/Guarantor: _____

Date: _____