GREENVILLE HEALTH CARE

Patient Registration (Patients information only)

Today's Date: _____ Gender: ____ Male ____ Female

Patient Name: _____ Date of Birth: _____

Address: _____
Street City State Zip Code

Name of Parent or Guardian (minors): _____

Home Phone #: _____ Cell Phone #: _____

Email: _____ Social Security #: _____ - _____ - _____

Marital Status (circle one): Married Divorced Widowed Single

Insurance Information

Insurance Company: _____ Policy Holder: _____

Member ID: _____ Group #: _____

If patient is not the policy holder, please provide the following:

Policy Holder's Date of Birth: _____ Policy Holder SSN #: _____ - _____ - _____

Emergency Contact

Contact Name: _____ Phone #: _____

Alt. Phone #: _____ Relationship: _____

Please be sure to fill out both sides of this form.

Authorization of Disclosure of Information

I _____, the patient, authorize the full disclosure of my entire medical record including but not limited to patient histories, office notes, test results, radiology studies, films, consults, alcohol/drug treatment, mental health information, HIV-related information, billing records, insurance records, and records sent by other physicians to the following individual(s).

_____	_____	_____
Name of Individual	Relationship to patient	Contact number
_____	_____	_____
Name of Individual	Relationship to patient	Contact number

I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of the disclosure. Information re-disclosed by the recipients listed in this authorization will not be the liability of the physicians. Authorization maybe be revoked in part or in full at any time with a written or verbal authorization by the patient.

_____	X_____	_____
Printed Patient Name	Patient Signature	Date

Please be sure to fill out both sides of this form.