HILTON HEAD HOSPITAL
Extraordinary Care right here at home

Volunteers in Medicine
Patient Information Sheet

Label

(Please print clearly)

_____ _____ _____ _____
Last Name **First Name** **M I** **Title** (Jr, Sr, etc.)

Sex: M F **Date of Birth**:_____/ _____/ _____ **Marital Status**: Married, Single, Divorced, Widowed, Separated, Life Partner

Race: Asian, Black, Native Amer, Pacific Isl, White **Ethnicity:** Hispanic, Non Hispanic **SS#**_____-_____-_____

_____ _____ _____ _____
Mailing Address City ST Zip

Phone #'s: Home: (_____) _____-_____ Cell: (_____) _____-_____

Email: _____ **Access to Patient Portal electronic medical record?** YES or NO

Are you in a Clinical Research Study? ❒ Yes ❒ No

Guarantor Name (If other than patient):_____
DOB:_____

Relationship to patient:_____

EMERGENCY CONTACT:

Name: _____Relationship_____Phone:_____

Patient/Responsible Party Signature: _____**Date**_____

SUBMIT