# **Southside Medical Center**:

3919 Hwy 14, Bldg. A
Greenville, SC 29615

## Patient Registration

| Date: | Social Security #: | Sex: | |
|---|---|---|---|
| Patient Last Name: | Patient First Name: | Middle initial: | Birthday: |
| Street Address: | City: | State: | Zip Code: |
| Patient's home phone | Patient's cell phone | Patient's work phone | Patient's E-mail |

Name of Employer: _____

What is the name, phone# and location of your pharmacy?
_____

May we leave a message on your phone or answering machine? YES ( ) NO ( )

May we e-mail you with information regarding test results? YES ( ) NO ( )

Do you have any special needs or instructions regarding your care? YES ( ) NO ( )

If yes please explain: _____

| Emergency Contact Name: | Relationship to you: | Emergency contact home #: | Emergency contact cell#: |
|---|---|---|---|
| | | | |

Do you have any medication allergies? YES ( ) NO ( )

If yes please list: _____

## Please read and sign below:

I authorize the release of any medical information necessary to process health insurance claims. I request payment of the benefits to be made to Southside Medical Center, PA. Any unexpected balance left after the insurance payment has been received will be due in full within 30 days of notification from this office. I further understand that any sums due me, if less than $130.00, will be credited to my medical account.

I have read and understand the above statements and I agree to them. I have provided truthful information to the best of my knowledge.

Signature: _____ Date: _____