Greenville Medical Associates

PATIENT REGISTRATION FORM

Today's Date:

PATIENT INFORMATION

Patient's Last name:	First:	Middle:	Marital status:

If not, what is your legal name?	Former name:	Birth date:	Age:	Sex: M/F/Other	

Address:

Social Security no.:	Home phone no.:	Cell phone no.:
Occupation:	Employer:	Employer phone no.:

Referred by If any:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Is this person a patient here?	◯ Yes ◯ No	Is this patient covered by insurance?	◯ Yes ◯ No

Please indicate primary insurance Name:

Subscriber's name:	Subscriber's SSN#.:	Birth date:	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Greenville Medical Associates or insurance company to release any information required to process my claims.

Patient/Guardian signature Date

- Main Office: 545 W Butler Rd, Greenville, SC 29607, Appointments: (864) 299-1990
- Cherrydale Office: 2601 N Pleasantburg Dr, Greenville, SC 29609, Appointments: (864) 299-1990