## SOUTH CAROLINA SURGICAL PATIENT INFORMATION FORM

**YOUR ADDRESS:** _____

**CITY:** _____ **STATE:** _____ **ZIP CODE:** _____

**PHONE #** _____ **CELL PHONE #:** _____

**SSN:** _____

**EMAIL ADDRESS:** _____

**Employer:** _____ **Employer Phone:** _____

**SIGNIFICANT OTHER/CAREGIVER/EMERGENCY CONTACT:**

Name:_____ Phone #: _____ Relationship to you: _____

Name:_____Phone #: _____Relationship to you:_____

**Do you have an advanced directive / Living will?:** _____**Yes. Did you bring a copy with you?** _____

(This is about your health, not your money) _____ **No**

**YOUR PRIMARY CARE PROVIDER:** _____

**Other providers/specialists:**

Cardiology:_____ Nephrology: _____

Wound care:_____ Oncology: _____

Orthopaedics: _____ Ophthalmology: _____

GI: _____ Gyn: _____

Other: _____

**YOUR PHARMACY NAME:** _____

**ADDRESS**_____**PHONE NUMBER** _____

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