WACCAMAW DERMATOLOGY
Skin Cancer Institute

Phone: (843) 449-0453 Fax: (843) 449-9531
www.waccamawdermatology.com

Demographic and Payment Information

Today's date ____/____/____

Name _____
Last First M.I.

Mailing Address _____
Street Unit City State Zip Code

Home Phone_____ Cell Phone_____ Work Phone_____

Date of Birth _____/_____/_____ Age _____ Sex _____ Social Security # _____

Partnership Status _____ Email _____

Employer / School _____

Ethnicity-Race (circle) African American Asian American Indian Caucasian Other _____
Ethnicity (circle) Non-Hispanic/Latino OR Hispanic/ Latino
Language (circle) English Spanish Russian French German Other _____

PARENT OR GUARDIAN OF MINOR CHILDREN OR POWER OF ATTORNY (POA) OR EMERGENCY CONTACT
Name _____
Last First M.I

Home Phone _____ Cell Phone _____ Work Phone _____

INSURANCE INFORMATION (Please present insurance cards at check in)

Primary Insurance Name_____ **Secondary Insurance Name**_____

Name of Insured _____ Name of Insured_____

Insured ID # _____ Insured ID #_____

Insured's SSN _____ Insured's SSN _____

Insured's Date of Birth _____ Insured's Date of Birth_____

Relationship to Insured_____ Relationship to Insured _____

Pharmacy Information

Name _____ Phone number _____

Signature of patient or guardian _____ Date _____