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.

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

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 _____

Home Phone:_____ **Work Phone:** _____ **Cell Phone:** _____

Email Address: _____ **Partnership Status:** _____

Mailing Address: _____
Street Unit City State Zip Code

Pharmacy/Location: _____

Primary Care Provider: _____

Referring Provider (if referred): _____

How did you hear about us? _____

Insurance
Insurance Company: _____ ID#: _____

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 _____

Signature of patient or guardian _____ Date _____