SKIN SURGERY CENTER OF VIRGINIA

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Demographic Sheet

Required information for Registration and your Electronic Medical Record

Last Name: _____ First Name: _____ Middle Initial: _____ Suffix: _____

Sex: [ ] Male [ ] Female Date of Birth: _____ SS # _____ Occupation: _____

Mailing Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ [ ] Same as Cell Phone Work Phone: _____

Cell Phone: _____ [ ] None Email: _____ [ ] No Email

Contact Preference: [ ] Home Phone [ ] Cell Phone [ ] Work Phone [ ] Home Address

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Race: _____ [ ] declined Ethnicity: _____ [ ] declined

Primary Language: [ ] English [ ] Spanish [ ] Other _____

Marital Status: [ ] Single [ ] Married [ ] Separated [ ] Divorced [ ] Widowed [ ] Partner

How did you hear about us? _____

GUARDIAN: Do you have a Guardian? [ ] Yes [ ] No If yes, please provide name below.

Last Name: _____ First Name: _____ Middle Initial: _____ Suffix: _____

EMERGENCY CONTACT:

Last Name: _____ First Name: _____ Middle Initial: _____ Suffix: _____

Relationship: _____ Phone: _____ [ ] Home Phone [ ] Cell Phone [ ] Work Phone

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GUARANTOR: PARENT OR RESPONSIBLE PARTY (if different from patient)

Last Name: _____ First Name: _____ Middle Initial: _____ Suffix: _____

Mailing Address: _____ City: _____ State: _____ Zip Code: _____

Guarantor SS#: _____ Relationship to Patient: _____

Employer: _____ Occupation: _____

Phone: _____ [ ] Home Phone [ ] Cell Phone [ ] Work Phone

Email _____ [ ] No Email Date of Birth: _____

PRIMARY CARE PROVIDER: Office Phone Number: _____

First Name: _____ Last Name: _____ [ ] M.D. [ ] D.O. [ ] PA-C [ ] N.P. [ ] Other _____

REFERRING PROVIDER: Office Phone Number: _____

First Name: _____ Last Name: _____ [ ] M.D. [ ] D.O. [ ] PA-C [ ] N.P. [ ] Other _____

INSURANCE INFO: Please present *insurance card* and *driver's license* during check in. Complete ***only*** if you're ***not*** the policy holder.

Primary Insurance: _____ Secondary Insurance: _____

Name of Insured: _____ Name of Insured: _____

SS # _____ Date of Birth _____ SS # _____ Date of Birth _____

Relationship to policy holder _____ Relationship to policy holder _____