SKIN SURGERY CENTER OF VIRGINIA

Christine S. Rausch, MD, FACMS
William F. Schleicher, MS, MD

Gaskins Professional Office Park
2510 Gaskins Road
Henrico, VA 23238

804.282.4940 PHONE
804.282.4941 FAX
www.mohsvirginia.com

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: _____ [ ] MD [ ] DO [ ] PA-C [ ] NP [ ] Other _____

REFERRING PROVIDER: Office Phone Number: _____

First Name: _____ Last Name: _____ [ ] MD [ ] DO [ ] PA-C [ ] NP [ ] Other _____

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

Primary Insurance: _____ Secondary Insurance: _____

Name of Insured: _____ Name of Insured: _____

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

Relationship to policyholder _____ Relationship to policyholder _____