Patient Demographic Information

T. Scott Jennings, MD

Ward A. Katsanis, MD

(843)556-4380

Today's Date _____ Date of Birth _____ Title (Ms., Miss., Mrs., Dr.) _____

Last Name _____ First Name _____ Middle Initial _____

Street Address _____ Apt # _____

City _____ State _____ Zip Code _____

Mailing Address (if different) _____

County _____ Social Security # _____

Email _____ Home Phone _____

Cell Phone _____ Work Phone _____

Emergency Contact _____ Phone _____ Relation _____

Address _____ City, State, Zip Code _____

(Please circle one)

Race:	Asian ~ Black ~ Hispanic ~ White ~ Other _____
Language:	English ~ Spanish ~ French ~ German ~ Other _____
Sex:	Male ~ Female ~ Transgender
Marital Status:	Single ~ Married ~ Divorced ~ Separated ~ Widow
Student Status:	None ~ Full-Time ~ Part-Time
Employment Status:	Not Employed ~ Full-Time ~ Part – Time ~ Self-Employed ~ Military Active Duty ~ Retired

Employer Name _____

Employer's Address _____

Work Phone _____ OK to call? Yes _____ No _____

Referred by _____ Phone _____
First Name Last Name

Primary Care Doctor _____ Phone _____
First Name Last Name

Pharmacy _____ Phone _____

Pharmacy Address _____

Primary Insurance Information:	Secondary Insurance Information:
Insurance Name:	Insurance Name:
Policy #:	Policy #:
Group #:	Group #:
Name of Insured:	Name of Insured:
Insured's Date of Birth:	Insured's Date of Birth:
Insured's SSN:	Insured's SSN:
Insured's Relationship to Patient:	Insured's Relationship to Patient: