CENTER FOR Skin & Cosmetic DERMATOLOGY

Patient Information

Phone (817) 921-2838

Due to the exceeding amount of information required for the specialist's office to process and submit a claim, please complete ALL PORTIONS of this form. It is also crucial that you spply the physician and staff with your most current and up-to-date insurance information. You will be asked to update this information at a minimum of annually. Your patience and diligence is much appreciated

Patient's Name _____
First Middle Last

Address _____
Street & Apt # City State Zip

(please mark the box next to each phone number indicating whether or not the physician or staff may leave a message)

Home Phone _____ ❒No ❒Yes **Work Phone** _____ ❒No ❒Yes **Other Phone** _____ ❒No ❒Yes

Employer _____ E-mail _____

Any restrictions for contacting you? _____

Age _____ **Birthdate** _____ **Social Security Number:** _____

Marital Status ❒ Single ❒ Married to: _____ Gender: ❒ Female ❒ Male

Primary Care Physician: _____ Phone: _____

Emergency Contact _____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Other Phone _____

Primary Insurance Company (name): _____

Policy # _____ Group # _____ Ins. Phone _____

Referral Required? ❒ No ❒ Yes

Name of Policy Holder: Policy Holder Birth Date: SS#

Secondary Insurance Company (name): _____

Policy # _____ Group # _____ Ins. Phone _____

Referral Required? ❒ No ❒ Yes

Name of Policy Holder: Policy Holder Birth Date: SS#

Consent for Examination, Treatment and Financial Responsibility Agreement

I am at least 18 years of age, or, if not I am accompanied by a legal guardian. I hereby consent to and authorize a examination by my doctor and such assistant or staff as may be assigned by him/her. If appropriate, I authorize the release of any medical information for the purpose of processing insurance claims on my behalf. I understand it is my responsibility to provide current up-to-date insurance information prior to treatment. I also acknowledge that the filing of an insurance claim(s) is NOT A GUARANTEE OF PAYMENT, and that I AM FINANCIALLY RESPONSIBLE FOR PAYMENT if such claim(s) are unpaid. I authorize payment of medical benefits directly to the doctor for service(s) provided to me. A copy of this authorization shall be considered as valid as the original. I authorize the Center for Skin & Cosmetic Dermatology, to FAX my records to any physician or pharmacy for the purpose of coordinating or managing my healthcare.

For cosmetic services not covered by health insurance,I understand that charges are payable on or before the day service is rendered. I understand that photography is at times necessary part of planning and evaluating treatment, and hereby authorize the taking of photographs at the direction of the physician and/or delegate, solely for documentation purposes and recognize they will be kept confidential unless otherwise disclosed. I understand I am ULTIMATELY responsible for payment of services rendered.

Signature _____ **Date** _____
Patient or Parent/Guardian