W E L C O M E

Fort Worth Dermatology Associates, PA

Thank you for selecting our healthcare team! We will strive to provide you with the best possible healthcare. To assist us in meeting all your healthcare needs, please complete this form in its entirety. If you have any questions or need assistance, please contact us and we will be happy to assist you.

1. PERSONAL INFORMATION

Today's Date_____ _____M _____F_____Minor

Patient Name:_____Birthdate: _____

Address: _____

City:_____State:_____Zipcode: _____

Social Security #_____DL# _____

Employer:_____Occupation: _____

Referred by: _____

2. PHARMACY INFORMATION

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone Number: _____

3. CONTACT INFORMATION

Home phone:_____Work Phone:_____Cell Phone: _____

Email address: _____

Preferred method of contact: Phone _____ Email _____ Text _____

Emergency Contact :

Name:_____Phone#_____Relationship _____

INFORMATION REGARDING YOUR CONDITION, TREATMENT OR DIAGNOSIS CAN BE GIVEN TO:

Name:_____Phone # _____

Relationship: _____

4. PRIMARY INSURANCE

Primary Insured:_____Date of birth: _____

Relationship to patient: _____

Insurance Company Name: _____

Insurance Company Claims Address: _____

Group number: _____ ID# _____

5. AUTHORIZATION AND RELEASE

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child or the person for whom I am responsible during the period of such care to third party payers and/or other health practitioners.

I authorize and request my insurance company to pay directly to the doctor any insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I Agree to be responsible for payment of all services rendered on behalf of myself or my dependent.

_____ Date: _____

Signature of patient or parent, if minor

ADVANCED DIRECTIVE AND MEDICAL POWER OF ATTORNEY:

Do you have an Advance Directive for your medical care? _____

If yes, who is the designated person that will make decisions for you in the event that you are unable to do so: _____

Signature of patient or parent, if minor