Center for Skin & Cosmetic Dermatology
Phone: 817.921.2838 Fax: 817.921.2833
www.mytotalskincare.com

Patient & Insurance Information

_____ **Patient Name (PRINT)**	___/___/___ **Date of Birth**	M F *Circle* **Sex of Patient**	___/___/___ **Today's Date**

_____
Address **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** Y N	( ) _____-_____ □ □ **Work Phone** Y N	_____ **Occupation**	( ) _____-_____ □ □ **Alt./Cell Phone** Y N
_____ **EMERG. CONTACT NAME**	( ) _____-_____ **EMERGENCY CONTACT #**	_____ **E-Mail Address**	
_____ **Social Security Number**	**M S W D Minor** **Marital Status** *(please circle)*	_____ **Primary Care Physician**	( ) _____-_____ **Primary Care Physician**

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

PRIMARY Insurance Coverage

_____ PPO other:_____ ( ) _____-_____
Insurance Company Name Insurance Claims/Verification Phone

_____ _____ _____
Name of Policy Holder & Relationship to Patient D.O.B. of Policy Holder SSN of Policy Holder

SECONDARY Insurance Coverage

_____ PPO other:_____ ( ) _____-_____
Insurance Company Name Insurance Claims/Verification Phone

_____ _____ _____
Name of Policy Holder & Relationship to Patient D.O.B. of Policy Holder SSN of Policy Holder

I am at least 18 years of age, or, if not am accompanied by a legal guardian. I hereby consent to and authorize a history examination by my doctor and such assistant or staff as may be assigned 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 the responsibility of the patient to provide current up-to-date insurance information to the office of the physician prior to treatment. I also acknowledge the filing of insurance claims is NOT A GUARANTEE OF PAYMENT, and that I AM FINANCIALLY RESPONSIBLE FOR PAYMENT if such claim/claims are unpaid. I authorize payments of medical benefits directly to the doctor for services provided to me. A copy of this authorization shall be considered as valid as the original. I authorize Center for Skin & Cosmetic Dermatology, Malouf Dermatology, P.A., to FAX my records to any physician or pharmacy for the purpose of coordinating or managing my healthcare.

_____ **PATIENT SPOUSE PARENT GUARDIAN** ___/___/___
Signature Relationship (*please circle*) Date