# Houston Dermatology Associates, P.A.

www.houstondermatologyassociates.com

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## PATIENT REGISTRATION

## PATIENT INFORMATION

| PATIENT NAME (LAST, FIRST, MIDDLE) | TODAY'S DATE | MARITAL STATUS S M W D<br>SEX MALE FEMALE |
|---|---|---|
| STREET ADDRESS | | DATE OF BIRTH |
| CITY STATE ZIP CODE | | HOME PHONE NUMBER |
| SOCIAL SECURITY NUMBER | TEXAS DRIVERS LICENSE NUMBER | CELL PHONE NUMBER |
| SIGNATURE OF PATIENT | EMAIL | WORK PHONE NUMBER |

| PATIENT'S EMPLOYER | PATIENT'S OCCUPATION (Indicate if Student) |
|---|---|
| SPOUSE OR NEAREST RELATIVE | RELATIONSHIP |
| OCCUPATION OF SPOUSE | ADDRESS OF SPOUSE OR NEAREST RELATIVE |

## INSURANCE INFORMATION (PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST)

☐ COMMERCIAL ☐ MEDICARE ☐ SELF-PAY ☐ OTHER

| INSURANCE COMPANY | | PHONE NUMBER |
|---|---|---|
| POLICY HOLDER'S NAME / EMPLOYER | | RELATIONSHIP TO PATIENT |
| POLICY HOLDER'S D.O.B. | ID / POLICY NUMBER | GROUP NUMBER |
| ADDRESS | CITY STATE ZIP | |

## SECONDARY INSURANCE INFORMATION

| INSURANCE COMPANY | | PHONE NUMBER |
|---|---|---|
| POLICY HOLDER'S NAME | | RELATIONSHIP TO PATIENT |
| POLICY HOLDER'S D.O.B. | ID / POLICY NUMBER | GROUP NUMBER |
| ADDRESS | CITY STATE ZIP | |

## REFERRAL INFORMATION

| REFERRED BY FAMILY MEMBER OR FRIEND. PLEASE GIVE NAME. | WERE YOU REFERRED BY A PHYSICIAN?<br>YES NO | REFERRING PHYSICIAN'S NAME |
|---|---|---|

## PARENT / LEGAL GUARDIAN IF PATIENT IS MINOR

THE PARENT / LEGAL GUARDIAN WHO BRINGS IN THE MINOR CHILD WILL BE RESPONSIBLE FOR ALL COPAYMENTS AND DEDUCTIBLES. WE DO NOT FORWARD BILLS TO OTHER PARTIES REGARDLESS OF COURT RULINGS OR DIVORCE DECREES.

| LAST NAME | FIRST NAME | MIDDLE |
|---|---|---|
| ADDRESS | CITY STATE ZIP | |
| BY SIGNING BELOW, I UNDERSTAND I WILL BE RESPONSIBLE FOR ANY CHARGES INCURRED FOR THE MINOR CHILD. | | DATE |