



NEW/UPDATED PATIENT INFORMATION FORM

Basic Patient Information

Patient Name (last, first, middle initial): _____ Date: ___/___/___

Nickname/Preferred Name: _____ Date of Birth: ___/___/___

Gender: Female Male SSN: _____ - _____ - _____ Driver's License: _____

Marital Status: Single Married Divorced Widowed Separated

Mailing Address: _____

City: _____ State: _____ ZIP code: _____

Home Phone: () _____ Work Phone: () _____ Cell: () _____

Email Address: _____

Occupation: _____ Student Retired Unemployed

Employer: _____ Employer Address: _____

Name and Phone number of Referring Physician: _____

Name of and Phone Number of Primary Care Physician, if different _____

Parent, Spouse, or Other Responsible Party (if different from patient)

Name (last, first, middle initial): _____

Date of Birth: ___/___/___ SSN: _____ Gender: Female Male

Marital Status: Single Married Divorced Widowed Separated

Mailing Address: _____

City: _____ State: _____ ZIP code: _____

Home Phone: () _____ Work Phone: () _____ Cell: () _____

Email Address: _____

Insurance Information – Primary

Insurance Company Name: _____

Group Number: _____ Policy Number: _____

Name of Policy Holder: _____ Date of Birth: ___/___/___

SSN: _____ Relationship to Insured: Self Spouse Child Other: _____

Employer: _____ Employer Address: _____

Insurance Information – Secondary (if applicable)

Insurance Company Name: _____

Group Number: _____ Policy Number: _____

Name of Policy Holder: _____ Date of Birth: ___/___/___

SSN: _____ Relationship to Insured: Self Spouse Child Other: _____

Employer: _____ Employer Address: _____

Emergency Contact Information

Name of Friend or Relative: _____

Relationship to Patient: _____ Address: _____

Day Phone: (____) _____ Evening Phone: (____) _____

Advance Directive/Power of Attorney Information

Do you have a health care agent/surrogate decision maker or lasting power of attorney (POA)? Yes No

If yes, name of agent/POA: _____ Address: _____

Day Phone: (____) _____ Evening Phone: (____) _____

If no, would you like to discuss your advance directive or surrogate decision maker? Yes No

Preventive Medicine Measures (leave blank if never or not applicable)

Date of Last Flu Shot: ___/___/___ Date of Last Pneumonia Vaccine: ___/___/___ Date of Last Tetanus Shot: ___/___/___

Pharmacy Information

Pharmacy Name: _____

Address: _____

Phone: (____) _____ Fax: (____) _____

How did you hear about DFW Skin Surgery Center?

Newspaper Magazine Physician: _____ Family/Friend: _____ Yellow Pages

Direct Mail Our Website Other Website: _____ Other: _____

Release of information and assignment of benefits

I authorize the release of medical information to my primary care or referring physician, to consultants if needed, and as necessary to process insurance claims, insurance applications, and prescriptions. I also authorize payment of medical benefits to the physician.

Responsible Party Signature: _____ Date: ___/___/___

Relationship (if other than patient): _____