DFW Skin Surgery Center PLLC

1115 W. Randol Mill Rd
Suite 200
Arlington, TX 76012

2485 E. Southlake Blvd
Suite 200
Southlake, TX 76092

: (817) 303-MOHS (6647)
: (817) 303-6651
: www.dfwskinsurgery.com

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): _____