



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)

Last Flu Shot: ___/___/___ Pneumonia Vaccine: ___/___/___ Tetanus Shot: ___/___/___ Shingles Vaccine: ___/___/___

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 hereby authorize and assign all payments and/or insurance benefits for medical services rendered to me directly to DFW Skin Surgery Center, PLLC and its providers.

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

Relationship (if other than patient): _____