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)

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?

☐ Friend/Family ☐ Employee ☐ Physician: _____ ☐ Our Website ☐ Google

☐ Bing ☐ Facebook/Instagram ☐ Other Search Engine ☐ AI Suggestion ☐ Other Website: _____

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): _____