Cinco Ranch DERMATOLOGY

Patient Information:

First Name	MI	Last Name
Address	Phone	Cell
City	State	Zip
Email	Gender	Marital Status
SSN	Race / Ethnicity	Preferred Language
DOB	DL #/State	Student: Y | N
Employer	Employer Phone	Student: Full Time | Part Time
Referring Physician	Phone	Fax
Address	City	Zip
Emergency Contact (not in same house)	Phone	Relationship to Patient
Referral Source: Insurance Website | Patient Referral | Physician Referral | Web Search | Walk-In | ZocDoc | Katy Magazine | Website | Other		

Responsible Party Information (if other than patient)

First Name	MI	Last Name
Address	Phone	Cell
City	State	Zip
Relationship to patient		

Insurance Information:

Primary Ins Company	Effective Date	Member ID #
Ins Address	Ins Phone	Group No #
City	State	Zip
Insured's Name	Insured's DOB	Insured's SSN
Relationship to Patient	Insured's Gender	Insured's Phone
Insured's Employer / Phone / Address		

Secondary Ins Company	Effective Date	Member ID #
Ins Address	Ins Phone	Group No #
City	State	Zip
Insured's Name	Insured's DOB	Insured's SSN
Relationship to Patient	Insured's Employer	Insured's Phone
Insured's Employer / Phone / Address		

ALL SERVICES RENDERED ARE THE FINANCIAL RESPONSIBILITY OF THE PATIENT AND NOT THE INSURANCE COMPANY. OUR OFFICE WILL BILL YOUR INSURANCE COMPANY AS A COURTESY. YOUR FINANCIAL RESPONSIBILITY IS TO ENSURE THAT CINCO RANCH DERMATOLOGY IS PAID FOR SERVICES RENDERED.

I HEREBY AUTHORIZE CINCO RANCH DERMATOLOGY TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO CINCO RANCH DERMATOLOGY ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MY DEPENDENTS OR MYSELF. I UNDERSTAND THAT THIS AUTHORIZATION WILL REMAIN IN EFFECT FOR AS LONG AS MY DEPENDENT OR I REMAIN A PATIENT.

X_____ DATE _____

(SIGNATURE OF PATIENT OR GUARDIAN)