DERMATOLOGY & SKIN SURGERY INSTITUTE OF NORTH TEXAS

Patient Registration

Patient Information Date Completed ____/_____/_____

Full Name _____ Date of Birth ____/_____/_____
Last First MI

Address _____ Apt. # _____ Gender ❑ M ❑ F

City / State _____ Zip _____ Marital Status ❑ Married ❑ Single ❑ Divorced ❑ Widowed

Race ❑ American Indian/Alaska Native ❑ Asian ❑ Black/African American ❑ Native Hawaiian/Other Pacific Islander ❑ White ❑ Other _____

Language ❑ English ❑ Spanish ❑ Other

Ethnicity ❑ Hispanic or Latino ❑ Not Hispanic or Latino

Phone (Check preferred contact number):
Home ❑ _____ Cell ❑ _____ Work ❑ _____

Email Address _____ May we send you information here? ❑ Yes ❑ No

Social Security Number _____ Driver's License Number and State _____

Employer _____ Occupation _____

Employer's Address _____
Street City State Zip

Emergency Contact Person _____ Relationship _____

Emergency Contact Phone _____

Primary Care Physician _____ PCP Phone _____

Pharmacy _____ Location of Pharmacy _____
Our practice utilizes e-prescribing, where your prescription is sent to your pharmacy electronically. City / Intersection
If you prefer to have a paper prescription, please let the physician know.

How were you referred to our office? (Please check all that apply)

❑ Internet (Website: _____) ❑ Phone Book ❑ Advertisement _____

❑ Insurance Website ❑ Family / Friend ❑ Drive-By

❑ Doctor _____ ❑ Other _____

Insurance Information

Primary Insurance Name_____ Insurance Phone _____

Insured Person's Name _____ Date of Birth ____/_____/_____
Last First MI

Patient's Relationship to Insured: ❑ Spouse ❑ Child ❑ Other _____

Insurance ID # _____ Group # _____

Insurer's Employer_____

Secondary Insurance _____ Secondary Insurance ID # and Grp. #_____