DERMATOLOGY CENTER OF DALLAS

8230 Walnut Hill Lane, Professional Bldg. III, Suite 500, Dallas, TX 75231 214-739-5821 / Fax – 214-739-0713

James H. Herndon, MD   Peter D. Hino, M.D.   J. B. Foshee, M.D.

PATIENT REGISTRATION

ACCT#____________

PATIENT INFORMATION

Last Name: ______________________________First Name: ____________________ MI:______

Street Address: __________________________Apt #:_____City: ____________State:____ Zip _____

Home Phone: ( ) _____ - _____ Alternate Phone#: ( ) ______ - ______ □ work □ mobile

Date of Birth: ____/____/____ Age: _____ Sex:______ Email:______________________________

Employer: ______________________ Driver's License # ____________Spouse Name:____________

Referring Physician: ______________________________ Phone: _________________________

HEALTH INSURANCE INFORMATION

Insurance Company: ____________________________ ID#______________________________

Group#____ ____________ Relationship to Patient: ________ Ins. Co. Phone # _______________

Insured Name: ____________________ Date of Birth: ___/___/___ SSN#: _________________

PLEASE COMPLETE IF PATIENT IS A CHILD (UNDER 18 YEARS OLD)

Give information for the PARENT/LEGAL GUARDIAN who is accompanying child to this visit

Name: ______________________________ Relationship to Patient: _______________________

Address: ______________________City: __________________State: ___________ Zip: _______

Home Phone #: ( ) ______ - ______ Alternate Phone #: ( ) ______ - ______ □ work □ mobile

FINANCIAL RESPONSIBILITY: *I have read and understood the financial policy on the back of this registration* and agree that I am ultimately responsible for the balance of my account for any professional services rendered regardless of insurance coverage.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Dermatology Center of Dallas to release any information acquired in the course of my examination or treatment to the insurance carriers involved in the payment of my account. I authorize fax transmittal as needed.

ASSIGNMENT OF BENEFITS: I hereby authorize payment directly to Dermatology Center of Dallas.

SIGNATURE: ____ DATE: _______________