

# LAS COLINAS DERMATOLOGY, P.A.

ALISON A. BLACK, M.D.  
DERMATOLOGY AND DERMATOLOGIC SURGERY

## PATIENT INFORMATION

(ANSWER ALL QUESTIONS • CIRCLE CHOICES THAT APPLY • PRINT CLEARLY)

NAME OF PATIENT \_\_\_\_\_  
LAST FIRST MIDDLE

HOME ADDRESS \_\_\_\_\_  
STREET CITY STATE ZIP

HOME PHONE(\_\_\_\_) \_\_\_\_ - \_\_\_\_ DRIVER'S LIC.# \_\_\_\_\_ SSN \_\_\_\_\_

CELL PHONE(\_\_\_\_) \_\_\_\_ - \_\_\_\_ PREFERRED CONTACT # \_\_\_\_\_

WORK PHONE(\_\_\_\_) \_\_\_\_ - \_\_\_\_ EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_

SEX M F MARITAL STATUS S M W BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_\_ E-MAIL \_\_\_\_\_

### RESPONSIBLE PARTY/INSURED

NAME \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_  
LAST FIRST MIDDLE

HOME ADDRESS \_\_\_\_\_  
STREET CITY STATE ZIP

HOME PHONE(\_\_\_\_) \_\_\_\_ - \_\_\_\_ EMPLOYER \_\_\_\_\_ WORK PHONE(\_\_\_\_) \_\_\_\_ - \_\_\_\_

SS# \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

PAYMENT FOR OFFICE VISITS IS EXPECTED AT THE TIME OF SERVICE. HMO/PPO INSURANCE FOR WHICH DR. BLACK IS A PROVIDER WILL BE FILED FOR COVERED SERVICES. YOU ARE RESPONSIBLE FOR REFERRAL APPROVAL FROM YOUR PRIMARY PHYSICIAN IF REQUIRED BY YOUR PLAN, PAYMENT OF COPAYMENTS, CO-INSURANCE, AMOUNTS APPLIED TO YOUR DEDUCTIBLE, AND SERVICES NOT COVERED OR APPROVED BY YOUR INSURANCE COMPANY. SIGN HERE TO AUTHORIZE PAYMENT TO DR. BLACK AND TO AUTHORIZE US TO RELEASE FINDINGS OF OUR EXAMINATION TO YOUR PHYSICIAN OR YOUR INSURANCE COMPANY AS NECESSARY TO PROCESS YOUR CLAIM.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

### INSURANCE INFORMATION

PRIMARY CARRIER \_\_\_\_\_ PHONE #(\_\_\_\_) \_\_\_\_ - \_\_\_\_

ADDRESS \_\_\_\_\_

INSURED'S NAME \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

INSURED'S I.D. # \_\_\_\_\_ GROUP # \_\_\_\_\_ CO-PAY OR % \_\_\_\_\_