Welcome To Our Office!

Name: ____Today's Date: ___________________
First Middle Last

Home Address: ____
City: __________________________________ State: __________ Zip: _______________
Sex: Male / Female Marital Status: S M W D Drivers License #:__________
Telephone: ( ) ___________________ Birthdate: _________________ Age: ________
Email Address: __________________________________ May we send information here? Yes No
Occupation: _____________________________________ SSN: ______________________________
Employer: ____ Years There: _____________
Employer's Address: ____
City: __________________________________ State: __________ Zip: _______________
Work Phone: ( ) ______________________ Cell Phone: ( ) _______________________

Complete this section only if someone other than the patient is primary on the insurance.

Responsible Party: ____________________________________ Relationship to Patient: _________
Home Address: ____
City: __________________________________ State: ____________ Zip: ______________
Telephone: ( ) _____________________ Birthdate: ___________________ Age:________
Occupation: ____ SSN:_______________________
Employer: ____ Years There: _____________
Employer's Address: ____
City: __________________________________ State: __________ Zip: _____________
Work Phone: ( ) ______________________ Cell Phone: ( ) _______________________

Name of Spouse/Guardian: _________________________ Birthdate: ___________Age: _______
Occupation: ____ SSN: ________________________
Employer: ____ Years There: _____________
Employer's Address: ____
City: __________________________________ State: __________ Zip: ______________
Work Phone: ( ) ______________________ Cell Phone: ( ) _______________________

In case of emergency, contact: ________________________________ Relationship: ___________
Home Phone: ( ) _________________________ Work Phone: ( ) ______________________

Other than yourself, whom may we discuss your medical information with? (Please give the person's name and relationship to you.)

____
____
____

May we leave messages on your answering machine? Yes No
May we contact you at work? Yes No

(Over)

Insurance Information

Patient's Name:____ Today's Date:__________
First Middle Last

[Primary Insurance]
Name of Insurance Company:
____
Address: ____
City: _________________________________ State: _________ Zip: ______________
Insured's Name: ____
Group Number: ________________________ Policy ID Number: ____________________

[Secondary Insurance]
Name of Insurance Company:
____
Address: ____
City: _________________________________ State: _________ Zip: ______________
Insured's Name: ____
Group Number: ________________________ Policy ID Number: ____________________

Our office will file insurance for all reimbursable services, to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, copay, and non-covered service amounts. See our complete financial policy for details.

Signature of Patient or Responsible Party: ____

Date: _________________

I authorize the release of any medical information necessary to process my claim.

Signed: ________________________
(Patient or responsible party)

Date: _________________________

I authorize payment of medical and surgical benefits to Aubrey Chad Hartmann, M.D., P.A./Lone Star Dermatology.

Signed:_______________________
(Patient or responsible Party)

Date: _________________________

TREATMENT TO MINORS
Many times parents find themselves unable to accompany their teen or young child to appointments. This section has been prepared for your convenience should you at some time be unable to accompany your child to an appointment.
I hereby grant permission to Dr. Aubrey Chad Hartmann or Kelly Webb, PA-C to treat my child when they arrived at the office unaccompanied.

____ _________________
Signature of Parent or Guardian Date