Date:

Westside Dermatology Clinic , Pa.
1331 WEST GRAND PARKWAY NORTH
KATY TX 774932737
281-392-1177

Account #: ____________ DOB: ____________ Age: ________ Sex: ________
Patient Name: ______________________ Cell Phone: ____________
Address: ______________________ Home Phone: ____________
City, State, Zip: ______________
Email: ____________ Patient Employer: ______________
Race: ________ Ethnicity: ____________ Language: ____________

Pharmacy Name: ____________ Phone: ____________ Zip: ________

Emergency Contact: ____________ Relationship: ________ Phone: ____________

Referring Physician: ______________ Phone: ____________

Primary Insurance Information **Please have your insurance card and ID ready for scanning

Primary Ins.: ____________ ID/policy #: ________ Group #: ________
***If other than patient-
Name of Insured: ______________ DOB: ________

Secondary Ins.: ____________ ID/policy #: ________ Group #: ________
***If other than patient-
Name of Insured: ______________ DOB: ________

ATTENTION!!!!!!! NOTE: If your insurance requires a referral for you to see Dr. , it is your responsibility to provide our office with the referral. If your insurance company denies payment - DUE TO NO REFERRAL - You the patient agree to pay Westside Dermatology Clinic , Pa. in full for any charges incurred.

Some PPO insurance plans consider the copay for office visit only. Procedures - freezing, biopsy, mole removal is considered office surgery and applied to your deductible, which you will be responsible for. I agree to pay for any charges (skin tags & lipoma) if my insurance states they are cosmetic.

______________________ Today's Date: ____________
Signature of Patient/Guardian/Responsible Party

Notice of the Privacy Policy

Dr. Subrt and I agree that my medical records are private documents that we both jointly own. A Notice of Privacy Practices, which contains more information related to this subject, is available for my review.

Please INITIAL any of the following that apply to you:
I ALLOW TEXT MESSAGES ____________ I ALLOW VOICE MESSAGES

I ALLOW RELEASE OF RECORDS or BILLING TO MY INSURANCE COMPANY AND FAMILY:

I DO NOT ALLOW RELEASE OF RECORDS or BILLING:

______________________ Today's Date: ____________
Signature of Patient/Guardian/Responsible Party