Westside Dermatology Clinic, P.A.

1331 West Grand Parkway North Ste 370, Katy, TX 77493
Ph: 281-392-1177 Fax: 281-392-1125

Patient Name _____ DOB: _____ Sex: _____
Address: _____ Cell Phone: _____
City, State, Sip: _____ Home Phone: _____

Email: _____ Patient Employer: _____

Referring Physician: _____ Phone: _____
If No Referring Physician, Please Indicate: "N/A"

Primary Care Physician: _____ Phone: _____
If No Primary Care Physician, Please Indicate: "N/A"

Emergency Contact: _____ 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. Subrt, 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 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 one of the following:

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