Central Austin Dermatology, P.A.
Patient Registration (fax to 512-302-9723)

Patient Information

Circle one below:

Male Female

Married Single

Last name | First name | MI | Date of Birth | SSN (required)

Street | City | State | ZIP

Employer | Employer address

Home phone | Work phone

Emergency contact | Relationship to patient | Emergency phone

Guarantor (Responsible Party) Information

Students **must** provide a permanent mailing address!

Last name | First name | MI | Relation to Patient | Date of Birth

Street | City | State | ZIP | SSN

Employer | Employer address

Home phone | Work phone

Insurance Information

Insured's Last name | First name | MI | Date of Birth | SSN

Street | City | State | ZIP

Insured's Employer | Employer address | Employer phone

Verified by: _____

Phone: _____

Insurance Company (Primary) | Policy number | Group number

Insurance Co. (Primary) Address (from your Insurance Card) | Ins. Co. Phone

Verified by: _____

Phone: _____

Insurance Company (Secondary) | Policy number | Group number

Insurance Co. (Secondary) Address | Ins. Co. Phone

Referring Physician

Name | Address/Phone

I, the undersigned, assign directly to Central Austin Dermatology, P.A. all surgical and/or medical insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am fully responsible for all charges whether or not paid by insurance. I hereby authorize Central Austin Dermatology, P.A. to release any and all medical records information required by my insurer to secure the payment of benefits.

(Signed) _____ (Date) _____