131 W. Sunset Rd, Suite 101
San Antonio, Texas 78209
Office: (210) 255-8447
Fax: (210) 255-8446

ENROLLMENT FORM

PATIENT INFORMATION (PLEASE PRINT)

Last Name	First Name	M.I.	
Mailing Address (Please include Apartment/Unit #)	City □ Check here for San Antonio	State □ TX	Zip Code
Home Phone # □ *Check here if this is the best contact number*	Work Phone #	Date of Birth	Sex □ Male □ Female
Cell Phone # □ *Check here if this is the best contact number*	Email address:		
If Patient under age of 18 Mother's Name:	If Patient under age of 18 Father's Name:	Patient's Driver's License # and State (if patient is under 18, please list parent DL# and State):	
Name of Emergency Contact	Relation	Emergency Contact Phone #	
Primary Insurance □ *Check here if new insurance (eff: _____)*	Policy/Member #	Group #	
Primary Insurance Policyholder's Name □ *Check here if Self*	Primary Insurance Policyholder's D.O.B.	Primary Insurance Policyholder Relation to Patient	
Secondary Insurance □ *Check here if new insurance (eff: _____)*	Policy/Member #	Group #	
Secondary Insurance Policyholder's Name □ *Check here if Self*	Secondary Insurance Policyholder's D.O.B.	Secondary Insurance Policyholder Relation to Patient	
Tertiary Insurance □ *Check here if new insurance (eff: _____)*	Policy/Member #	Group #	
Tertiary Insurance Policyholder's Name □ *Check here if Self*	Tertiary Insurance Policyholder's D.O.B.	Tertiary Insurance Policyholder Relation to Patient	

□ Primary Care Physician
Last Name: First Name: Office #:

Address: City/State: Zip Code: Fax #:

□ Referring Physician
Last Name: First Name: Office #:

Address: City/State: Zip Code: Fax #:

How did you hear about us? □ Google Search □ Yahoo Search □ Bing Search □ Other Internet search engine □ Yellow Pages □ Friends □ Family □ Referral from physician □ Magazine/Newspaper Ad □ Search on my Insurance company website □ Other:

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
I acknowledge that I have received a copy of Alamo Heights Dermatology's Notice of Privacy Practices. This notice describes how Alamo Heights Dermatology may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

RELEASE OF ALAMO HEIGHTS DERMATOLOGY MEDICAL RECOREDS TO HEALTH CARE PROVIDERS
I hereby consent and authorize Alamo Heights Dermatology to release any and all information in my medical records to my physician(s) and other health care providers involved with my care and treatment.

RELEASE OF MEDICAL RECORDS TO ALAMO HEIGHTS DERMATOLOGY
I hereby request and authorize my health care provider(s) to release to Alamo Heights Dermatology medical records, radiology reports, pathology reports or any other medical information as needed in assisting Alamo Heights Dermatology in providing my medical consultation, care and/or treatment.

I accept and agree to all of the provisions listed above.

_____ _____
Signature of Patient/Legally Authorized Person/Financially Responsible Party **Date**