RAJAN DERMATOLOGY

www.rajandermatology.com
6600 Bryant Irvin Road, Fort Worth, TX 76132
Tel: 817-820-0011

REGISTRATION

Date _____ Mobile Phone _____ Home Phone _____

PATIENT INFORMATION

Name: _____ S.S.# _____
Last First Middle Initial

Address: _____

City: _____ State: _____ Zip Code: _____

Sex: ☐ M ☐ F Age: Birthdate: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed by: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Who may we thank for referring you? _____

In case of emergency, who should be notified? _____ Phone: _____

PRIMARY INSURANCE

Person Responsible for Account: _____
Last First Middle Initial

Relation to Patient: Birthdate: S.S.# _____

Address (if different from patient's): _____ Phone: _____

City: _____ State: _____ Zip Code: _____

Person Responsible Employed by: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Insurance Company: _____

Contract #: Group #: Subscriber #: _____

Names of other dependents covered under this plan: _____

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ADDITIONAL INSURANCE

Is the patient covered by additional insurance? ☐ YES ☐ NO

Subscriber Name: Relation to Patient: Birthdate:

Address (if different from patient's): Phone:

City: State: Zip Code:

Subscriber Employed by: Business Phone:

Insurance Company: S.S.#

Contract #: Group #: Subscriber #:

Names of other dependents covered under this plan:

ASSIGNMENT & RELEASE

I the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ all the insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance or not. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature | Relationship | Date