

**Lubbock Dermatology & Skin Cancer Center**  
**Patient Information**

Today's Date \_\_\_\_\_

**Patient's Name** \_\_\_\_\_  
Last First Middle Maiden

Social Security Number \_\_\_\_\_  
Date of Birth (mo/day/yr) \_\_\_\_\_ Sex M \_\_\_\_\_ F \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone Home ( ) \_\_\_\_\_ - \_\_\_\_\_ Work ( ) \_\_\_\_\_ - \_\_\_\_\_ Mobil ( ) \_\_\_\_\_ - \_\_\_\_\_  
Employer \_\_\_\_\_ Employer's address \_\_\_\_\_  
Emergency contact person \_\_\_\_\_ Phone ( ) \_\_\_\_\_ - \_\_\_\_\_

**Spouse's Name** \_\_\_\_\_ Date of birth (mo/day/yr) \_\_\_\_\_  
Social Security Number \_\_\_\_\_ Employer \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone Home ( ) \_\_\_\_\_ - \_\_\_\_\_ Work ( ) \_\_\_\_\_ - \_\_\_\_\_ Mobil ( ) \_\_\_\_\_ - \_\_\_\_\_

**Who is responsible for patient's medical expenses? (Guarantor)** \_\_\_\_\_

**If patient is a minor-We need parent's information**

**Guarantor** Date of birth (mo/day/yr) \_\_\_\_\_ Social Security Number \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone Home ( ) \_\_\_\_\_ - \_\_\_\_\_ Work ( ) \_\_\_\_\_ - \_\_\_\_\_ Employer \_\_\_\_\_

**Your insurance company**

Primary \_\_\_\_\_ Secondary insurance \_\_\_\_\_

**NOTE:** You must complete the above information and submit your insurance cards to be copied or we cannot file your insurance. Patients are responsible for meeting all insurance requirements and deductibles at the time of service. **Insurance referrals are the responsibility of the patient.**

Who is your primary care physician? \_\_\_\_\_ Phone \_\_\_\_\_

Who/where is your pharmacy? \_\_\_\_\_ Phone \_\_\_\_\_

**Consent for treatment and release of information:** I consent to treatment by Richard Hope, M.D. and/or Justin Clark, M.D. and/or Amy Brackeen, M.D. and/or Cindy Reyna, RN, NP. I also authorize the above-mentioned to release, request, and/or obtain any or all of my medical information for consultation, referral and/or insurance purposes.

**Assignment of Benefits:** I authorize payment of medical benefits to the undersigned physician for services provided

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_

I authorize any subsequent treatment for my child, if I am unable to be here. \_\_\_\_\_  
Name & Relationship to Patient

- In order to provide quality care, we strive to have a complete and accurate medical history; therefore, please fill out the S-O-A-P medical records information form. Thank you.

**(PLEASE FILL OUT THE OTHER SIDE)**

**Notice:** You will receive one (1) statement if a balance remains on your account. A fee of \$15 will apply to any additional statements until the balance is paid.

\_\_\_\_\_  
Initial

**Acknowledgement of Receipt of Notice of Privacy Practices**

I have received a copy of this office's Notice of Privacy Practices which explains how my medical information may be disclosed.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient/Parent/Guardian

**If you wish for information to be released and/or discussed with a third party of your choice, please complete the following:**

I, \_\_\_\_\_, authorize Lubbock Dermatology, Dr. Richard Hope and/or Dr. Justin Clark and/or Dr. Amy Brackeen, M.D. and/or Cindy Reyna, RN, NP and staff to release information regarding my health and medical treatment to the person(s) listed below.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship to patient

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship to patient

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date