



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

PATIENT INFORMATION (PLEASE PRINT)

Mailing Address (Please include Apartment/Linit #) City In Check here for San Antonio State In TX Zip Code Home Phone #	Last Name		First Name			M.I.		
Cell Phone # In Check here if this is the best contact number	Mailing Address (Please include Apartment/Unit #)		City Check here for San Antonio			State \Box TX	Zip Code	
Email address:	Home Phone # □ Check here if this is the best contact number		Work Phone #			Date of Birth	□ Male	
Pather's Name: Pather's Name: Pather's Name: Pather's Name: Pather's Name: Primary Insurance Primary Primary	Cell Phone # □ Check here if this is the best contact number							
Primary Insurance Check here if new insurance (eff:				of 18 Patient's Driver's Lice please list parent DL#				
Primary Insurance Policyholder's Name Check here if Self Primary Insurance Policyholder's Primary Insurance Policyholder's Primary Insurance Policyholder Relation to D.O.B. Secondary Insurance Check here if new insurance (eff:	Name of Emergency Contact	Relation	Emergency Contact Phone #					
Secondary Insurance Check here if new insurance (eff:	Primary Insurance Check here if new insurance (eff:)		Policy/Member # Gro		Grou	roup #		
Secondary Insurance Policyholder's Name	Primary Insurance Policyholder's Name Check here if Self					Insurance Policyholder Relation to		
Tertiary Insurance Check here if new insurance (eff:	Secondary Insurance Check here if new insurance (eff:)		Policy/Member#		Grou	Group #		
Tertiary Insurance Policyholder's Name	Secondary Insurance Policyholder's Name Check here if Self					ry Insurance Policyholder Relation to		
□ Primary Care Physician Last Name:	Tertiary Insurance		Policy/Member # Gr		Gro	Group#		
Last Name: Address: City/State: Zip Code: Fax #: Office #: Address: Office #: Address: City/State: Office #: Address: City/State: Tip Code: Fax #: Office #: Address: City/State: Zip Code: Fax #: How did you hear about us? Google Search Again House Search Bing Search Other Internet search engine 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.	Tertiary Insurance Policyholder's Name		Tertiary Insurance Policyholder's					
□ Referring Physician Last Name: First Name: Office #: Address: City/State: Zip Code: Fax #:			Office #:					
Last Name: First Name: Office #: Address: 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.	Address: City/State:		Zip Code: Fax #:					
How did you hear about us? Google Search 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.			Office #:					
Referral from physician								
	Referral from physician Magazine/Newspaper ACKNOWLEDGEMENT OF RECEIPT OF NOTICE I acknowledge that I have received a copy of Alamo and disclose my protected health information, certain health information. RELEASE OF ALAMO HEIGHTS DERMATOLO I hereby consent and authorize Alamo Heights Derminvolved with my care and treatment. RELEASE OF MEDICAL RECORDS TO ALAMO I hereby request and authorize my health care providenced information as needed in assisting Alamo Heights Magazine/Newspaper ACKNOWLEDGEMENT OF NOTICE NOTICE TO NOTICE	Ad □ Search on my Ins DE OF PRIVACY PRACT Heights Dermatology's 1 In restrictions on the use a GY MEDICAL RECORI natology to release any an DHEIGHTS DERMATOL der(s) to release to Alamo deights Dermatology in pr	urance company website Other: TICES Notice of Privacy Practices. This not nd disclosure of my healthcare infor EDS TO HEALTH CARE PROVID id all information in my medical reco	cice describes mation, and rice to my physical restriction of the my physical restriction of	how Alanights I ma	no Heights Derma ny have regarding to and other health o	tology may use my protected	
Signature of Patient/Legally Authorized Person/Financially Responsible Party Date								