Pediatric Dermatology of North Texas

Patient Information

Last Name	First Name	M.I.

Address	City	State	Zip

Gender ○ Male ○ Female

D.O.B ___/___/___

Child lives with: (check all that apply)

○ Mom ○ Dad ○ Other _____

○ Step Mom ○ Step Dad ○ Grandparent _____

Parent Information

Mother's Last Name	Mother's First Name	D.O.B	Mom's Cell

Father's Last Name	Father's First Name	D.O.B	Dad's Cell

Primary E-mail Address to access the patient portal	Who referred you (PCP)? How did you hear about us?

Insured's

Subscriber's Last Name	Subscriber's First Name	Subscriber's D.O.B.

Subscriber's Address if different than Patient

Name of Insurance Company	Member ID	Group Number

Subscriber's Relation to Patient	Name of Employer	Insurance Company Phone #

Emergency Contact

Name	Phone #	Relation to Patient

Preferred Pharmacy

Pharmacy Name	Pharmacy Phone #	Street/Cross Streets	Zip