Kingwood Derm Spa

Steven J. Smith
19701 Kingwood Dr., BLDG. 6
Kingwood, Texas 77339

PATIENT LAST NAME _____ FIRST _____ MI _____

ADDRESS _____ HOME PHONE _____ CELL PHONE _____

CITY/STATE/ZIP _____ DATE OF BIRTH _____ AGE _____

OCCUPATION _____ SOCIAL SECURITY # _____

EMPLOYER _____ WORK PHONE _____

EMPLOYER'S ADDRESS _____

CITY/STATE/ZIP _____

CIRCLE ☐ CHILD ☐ SINGLE ☐ MARRIED ☐ WIDOW ☐ DIVORCED

REASON FOR THE VISIT TODAY _____

FULL NAME OF SPOUSE (If minor, name of parents) _____

ADDRESS _____ HOME PHONE ( ) _____

CITY/STATE/ZIP _____

OCCUPATION _____

EMPLOYER _____ WORK PHONE ( ) _____

RESPONSIBLE PARTY _____ PHONE ( ) _____

NAME OF INSURANCE COMPANY _____

POLICY HOLDER NAME _____ DATE OF BIRTH _____

POLICY HOLDER SOCIAL SECURITY # _____ SUBSCRIBER # _____

REFERRED BY _____ PHONE ( ) _____

EMERGENCY CONTACT _____ PHONE ( ) _____

HAS ANYONE IN YOUR HOUSEHOLD PREVIOUSLY BEEN A PATIENT OF DR. SMITH? ☐ YES ☐ NO

FULL NAME OF PREVIOUS PATIENT _____

AUTHORIZATION TO PROVIDE MEDICAL CARE:
I consent to treatment as necessary or desirable to the care of the patient first named above. Included but not restricted to whatever drugs, medicine and conduct of laboratory, X-ray, or other studies that may be used by the attending physician or said physician's nurse or qualified designate. Also acknowledge full responsibility for the payment of such service unless other arrangements are made in a advance with the finance department.

SIGNATURE: _____ DATE: _____