THOMAS DUNCAN NICHOLS, PH.D., M.D.
DERMATOLOGY AND SKIN SURGERY

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2424 WEST HOLCOMBE, SUITE 103
HOUSTON, TEXAS 77030

HOME 713-669-8099
TDNDERMATOLOGY@MSN.COM

PATIENT ACCOUNT NUMBER: _____

PATIENT INFORMATION *(PLEASE PRINT)*

PATIENT LAST NAME	FIRST NAME	MIDDLE INITIAL	BIRTHDATE	SEX	SOCIAL SECURITY NUMBER

MAILING ADDRESS	CITY	STATE	ZIP

STREET ADDRESS OR VICINITY (in event of an emergency)	

TELEPHONE NUMBER ( )	NAME OF SPOUSE (if applicable)

FOREIGN ADDRESS

DRUG ALLERGIES, IF ANY	MARITAL STATUS (S / M / W / D / Sep.)	DO YOU SMOKE?	DIABETIC?	PREVIOUS SKIN SURG.

MEDICATIONS: LIST ANY MEDICATIONS YOU TAKE DAILY, INCLUDE FREQUENCY AND AMOUNTS

REFERRING PHYSICIAN'S NAME	ADDRESS	PHONE ( )

PATIENT'S EMPLOYER	SPOUSE'S EMPLOYER
BUSINESS ADDRESS	BUSINESS ADDRESS
BUSINESS PHONE ( )	BUSINESS PHONE ( )

IN CASE OF EMERGENCY CONTACT: (Name of friend or relative not living with you)

LAST NAME	FIRST NAME	MIDDLE INITIAL	RELATIONSHIP	HOME PHONE ( )
ADDRESS, CITY, STATE, ZIP				HOME PHONE ( )

HEALTH INSURANCE INFORMATION

NAME OF INSURANCE COMPANY	MAILING ADDRESS OF INSURANCE COMPANY			PHONE
POLICY NUMBER OR CERTIFICATE NUMBER	GROUP NUMBER	NAME OF POLICY HOLDER		RELATION
NAME OF INSURANCE COMPANY	MAILING ADDRESS OF INSURANCE COMPANY			PHONE
POLICY NUMBER OR CERTIFICATE NUMBER	GROUP NUMBER	NAME OF POLICY HOLDER		RELATION
NAME OF INSURANCE COMPANY	MAILING ADDRESS OF INSURANCE COMPANY			PHONE
POLICY NUMBER OR CERTIFICATE NUMBER	GROUP NUMBER	NAME OF POLICY HOLDER		RELATION

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. THE PATIENT IS RESPONSIBLE FOR PAYMENT OF DOCTOR'S FEES WITHIN 30 DAYS REGARDLESS OF INSURANCE COVERAGE OR STATUS OF INSURANCE CLAIM(S). EXTENSION OF CREDIT BEYOND 30 DAYS MUST BE DISCUSSED AND APPROVED BY THE BUSINESS OFFICE IN ADVANCE. INSURANCE PAYMENTS RECEIVED WILL BE APPLIED TO YOUR ACCOUNT BALANCE OR PROMPTLY REFUNDED TO YOU. NECESSARY FORMS WILL BE COMPLETED AND FORWARDED TO THE ABOVE INSURANCE COMPANIES IN ORDER TO EXPEDITE INSURANCE CARRIER PAYMENTS.

INSURANCE AUTHORIZATION AND ASSIGNMENT *(PLEASE READ AND SIGN)*

I HEREBY AUTHORIZE THOMAS D. NICHOLS, M.D. TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO THE PHYSICIAN(S) ALL PAYMENT FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES REGARDLESS OF INSURANCE COVERAGE.

SIGNATURE _____ DATE _____