# DERMATOLOGY AND LASER CENTER
# OF FORT WORTH
# WILLIAM F. COTHERN, D.O., P.A.

## PATIENT FACT SHEET

DATE________________

PATIENT NAME ________________________DOB___________AGE___________

ADDRESS/CITY/STATE/ZIP_______________________________________________

_______________________________________________

MARITAL STATUS___________________SEX_____________

HOME PHONE_________________________CELL PHONE____________________________________

WORK PHONE_________________________EMPLOYER_____________________________________

SS NUMBER_______________________EMAIL ADDRESS____________________________________

REFERRED BY_______________________________________________________________________

RESPONSIBLE PARTY FOR BILLING, IF OTHER THAN PATIENT:

NAME___________________________________RELATIONSHIP______________________________

MAILING ADDRESS_____________________________________________DOB__________________

PHONE NUMBER__________________________SS NUMBER_________________________________

EMPLOYER NAME & PHONE NUMBER__________________________________________________

EMERGENCY CONTACT NAME & NUMBER_____________________________________________

DO YOU GIVE OUR OFFICE PERMISSION TO DISCUSS YOUR MEDICAL INFORMATION WITH FAMILY MEMBERS? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE NAME & PHONE NUMBER:

NAME_ ____________________________________PHONE NUMBER___________________________

MAY WE LEAVE PERSONAL MEDICAL INFORMATION ON YOUR ANSWERING MACHINE?
☐ YES ☐ NO

IF YES, WHAT NUMBER WOULD YOU LIKE US TO USE?
☐ HOME ☐ CELL ☐ WORK

MY SIGNATURE BELOW INDICATES HAT I HAVE RECEIVED AND REVIEWED A COPY OF OFFICE POLICIES AND HAVE BEEN ADVISED A COPY OF THE PRIVACY POLICIES FOR DERMATOLOGY & LASER CENTER OF FORT WORTH IS AVAILABLE TO ME FOR REVIEW.

PATIENT OR RESPONSIBLE PARTY SIGNANTURE_____________________________________________