FORT BEND
SKIN CANCER CENTER

Keith E. Schulze, M.D.
15400 Southwest Freeway
Suite 150
Sugar Land, TX 77478

Registration

Patient Information

_____ _____
(Last Name, First MIddle) *(Date of Birth)*

_____ _____
(Address) *(City, State, Zip Code)*

_____ _____ _____
(Home Telephone Number) *(Work Telephone Number)* *(Mobile Telephone Number)*

_____ _____
(Nickname or Preferred Name - If applicable) *(Prior Name – If applicable)*

Marital Status: ❑Single ❑Married ❑Divorced ❑Widowed
Sex: ❑Male ❑Female
Employment Status: ❑Employed ❑Retired ❑ Student ❑ Other

Employment Information

_____ _____
(Occupation) *(Employer)*

_____ _____
(Address) *(City, State, Zip)*

Spouse Information (If Applicable)

_____ _____
(Name) *(Date of Birth)*

Responsible Person (If Applicable)

_____ _____ _____
(Name) *(Date of Birth)* *(Relationship to Patient)*

_____ _____
(Address) *(City, State, Zip Code)*

_____ _____ _____
(Home Phone Number) *(Mobile Phone Number)* *(Occupation)*

_____ _____
(Employer) *(Employer Phone Number)*

****Please be aware that Dr. Schulze has an ownership interest in *The Central Houston Surgical Center*****

Dr. Schulze believes that this interest allows him greater influence over the care his patients receive. If you have any questions or concerns, please feel free to discuss them with Dr. Schulze.

Person to Contact in Case of Emergency

_____ _____ _____
(Name) *(Phone Number)* *(Relationship to Patient)*

_____ _____
(Address) *(City, State, Zip Code)*

Insurance Information
(Not needed if the receptionist has a copy of your insurance card(s))

1) _____ _____
(Primary Insurance) *(Phone Number of Insurance Company)*

_____ _____ _____
(Name of Guarantor/ Subscriber) *(Date of Birth)* *(Relationship to Patient)*

_____ _____
(Group Number) *(ID Number)*

_____ _____
(Address) *(City, State, Zip Code)*

2) _____ _____
(Secondary Insurance) / (If Applicable) *(Phone Number of Insurance Company)*

_____ _____ _____
(Name of Guarantor/ Subscriber) *(Date of Birth)* *(Relationship to Patient)*

_____ _____
(Group Number) *(ID Number)*

_____ _____
(Address) *(City, State, Zip Code)*

How were you referred to our office?

- ☐ **By a Doctor**
- ☐ **By a Friend**
- ☐ **By a Patient**
- ☐ **Other**

Please print the name of your referral source below.

_____

Who is your primary care physician? (Family Physician, Internist, or OB/GYN)

_____

Would you like us to send a copy of our findings and treatment outcome to this physician? ☐ **Yes** ☐ **No**

Consent to Treatment

I voluntarily consent to receive medical and health care services that may include diagnostic procedures examinations and treatment.

Financial Responsibility and Assignment of Benefits

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents. I will be bound by this signature as though I had personally signed the particular claim. I acknowledge and understand that I am responsible for all of the charges for the services rendered to me or any member of my family.

The information above is complete and accurate to the best of my knowledge.

I certify that I have read this form and understand its contents.

_____ _____
(Patient or Other Legally Authorized Person) *(Date)*