DERMATOLOGY
OF NORTH TEXAS
Robert T. Garbacz, D.O. FAAD

Patient Registration

Full Name: _____ Today's Date: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Sex: _____ Marital Status: _____ SSN: _____

Phone (H): _____ (C): _____ (W): _____

Email Address (necessary for patient portal): _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Employer: _____/Student/Retired/Other: _____ Race: _____ Ethnicity: _____

Preferred pharmacy Name: _____

City or Zip code:_____

Responsible party (Minors):_____Phone Number:_____

Relationship: _____ Address: _____

Insurance Subscriber: _____

*** If you are not the primary insured party,** please provide:

Name: _____ Date of Birth: _____ SSN: _____

Address (if different):_____

Phone number: _____ Relationship to Patient: _____

Who can we thank for referring you? Friend:____ Physician:____ Radio:_____ Google: _____ Other:____

Statement of Financial Responsibility

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

I hereby assign, transfer, and set over to Robert T. Garbacz, DO, all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medication information to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization in writing. **I understand that I am financially responsible for all incurred charges regardless of whether or not they are covered by insurance.**

Patient Name: _____ Signature:_____ Date: _____

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