Dermatology Associates of West Texas, LLP
2202 Ithaca Ave, Lubbock, TX 79410
806-797-1202

PATIENT REGISTRATION FORM

Name: _____ Sex: ☐ M ☐ F
First Middle Last

Preferred Name_____

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

Where should statements of your account be sent (if different from above)?

_____
Name Address City State Zip

Employer: _____ Occupation: _____

Home Phone:_____ Date of Birth: _____/_____/_____

Cell Phone: _____ Language: _____

Work Phone: _____ Race_____Ethnicity _____

email: _____

SPOUSE/PARENT (if patient is minor):_____

Spouse/Parent Date of birth: _____/_____/_____

Spouse/Parent Employer_____ Spouse/Parent Cell Phone_____

Emergency Contact Name/Number: _____
(SOMEONE NOT IN YOUR HOUSEHOLD)

Who Referred You? _____

Please present insurance cards to the receptionist for scanning.

Name of Policy owner if other than patient: _____

Date of Birth of Policy Owner____/_____/_____ Phone number of policy holder _____

Patient relationship to policy owner: ☐ Self ☐ Child ☐ Spouse ☐ Other

Appointment reminders are sent by text message. Check here if you want to opt out of text message. ☐
It is important that you keep your scheduled appointments. If you need to reschedule, please give us 24-hour notice so that the appointment time maybe filled with another patient. There will be a charge of $40.00 due from the patient for appointments which you fail to keep or cancel untimely.

Payment is expected from you, at the time of service for "your part" of the charges. We accept Visa/Mastercard/Discover.
If your insurance requires a referral from your primary care doctor, it is the patient's responsibility to obtain the referral.

_____ _____
Patient/Guardian Signature Date