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 $95.00 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