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P: (318) 321-5245 F: (318) 542-4322

Patient Registration Form

Patient Information:

Printed Name: _____

SSN: _____ DOB: _____

Email: _____

Address: _____

City/State: _____ Zip: _____

Home Phone: _(_____)_____-_____- Cell Phone: (_____)_____-_____-

Would you be interested in having communications sent to you via email? (Examples: appointment reminders, administrative updates, etc.) YES NO

Other Information:

Primary Care Physician: _____

Address/Location: _____

Preferred Pharmacy:

Pharmacy Name: _____ Address: _____

Person responsible for bill or parent (Complete only if different from patient)

Guarantor Name: _____ SSN: _____

Relationship to patient: _____ DOB: _____

Address: _____ Phone: _____

Emergency Contact:

Name: _____ Address: _____

Phone: _____ Relationship: _____

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to Dean Derm, I acknowledge that I am financially responsible for payment whether or not covered by insurance.

Patient/Guarantor Signature: * _____ Date: _____

*If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian.