4615 Parliament Dr. Suite 204 Alexandria, LA 71303
134 E 5th St. Natchitoches, LA 71457
Phone: 318.321.5245 Fax: 318.542.4322

DEAN DERM

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.