Paulger & Wisniewski Dermatology, LLP
2202 Ithaca Ave, Lubbock, TX 79410
806-797-1202

PATIENT REGISTRATION FORM

Date:_____

Name: _____Sex: M F
First Middle Last

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: _____/_____/_____
month day year

Cell Phone: _____

Work Phone: _____ Soc Sec. #: _____

email: _____

Spouse/Parent:_____Spouse/Parent Date of birth: _____/_____/_____
month day year

Spouse/Parent Employer_____Spouse/Parent Work Phone_____

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

Who Referred You? _____

Please present insurance cards to the receptionist so copies may be made.

Name of Policy owner if other than patient: _____

Social Security # of Policy owner: _____ Date of Birth of Policy Owner_____

Patient relationship to policy owner: Self Child Spouse Other Sex: M F

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 $55.00 due from the patient for appointments which you fail to keep or cancel.

Payment is expected from you, at the time of service for "your part" of the charges. We accept Visa and Mastercard for your convenience. You herein authorize payment of medical benefits to the Doctor when an assigned claim is filed. Your signature below indicates that you understand and accept this policy

Your signature is also acknowledging receipt of the Notice of Privacy Practices.

_____ _____
Patient Signature Date