DPC Member Registration Form

Last Name:	Referred by:
First Name:	
Middle Name:	How did you learn about DPC?
Legal Name (if different from above):	
Date of Birth (MM/DD/YYYY):	
Marital Status (check one box): Single ☐ Married ☐	**Sex (check one box):** Male ☐ Female ☐ Other ☐
Email address	
☐ *I consent to having my medical information sent to my email address (We cannot guarantee security of messages)*	
Personal Contact Information: Street Address	
Suite or Apt Number	
City	
State	
Zip Code	
Mobile Phone	
Home Phone	
Work Phone	
Employment Contact Information: Employer Name	
Street Address	
Street Name	
City	
State	
Zip Code	
Work Phone	
Pharmacy Contact Information:	
Preferred Pharmacy Name	
Pharmacy Address	
Pharmacy Phone Number	
Pharmacy Fax Number	
Billing Information: Member : ☐ Third Party: ☐ Employer: ☐ Billing Phone #: Billing email:	Billing First Name: Billing Last Name: Billing Card #: CVC Code: Card Expiration Date: Billing Start Date:
☐ *Credit card monthly auto-payment required for membership fees. I hereby authorize Lagniappe Medical Center to deduct the payment amount monthly on the Start Date indicated above from my Debit/Credit card account.*	
Emergency Contact Information	Name: Relationship: Contact phone #1: Contact phone #2:

The above information is true to the best of my knowledge and I understand that I am financially responsible for any balances beyond the membership plan at the cash pay rate. Minimum of six month membership required.

Member Signature ____ **Date:** ____________________________