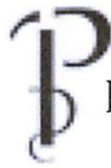

Professional Dermatology Care, PC

Intake Form

Name: ______________________________ Date of Birth: ____/____/____

Street Address: ______________________________

City: ______________________ State: __________ Zip: ______________

Phone Number: ______________________ Alt. Number: ______________________

Email Address: ______________________________

Emergency Contact: ______________________ Phone: ______________________

Primary Care Physician: ______________________ Phone: ______________________

Referring Doctor: ______________________ Phone: ______________________

Pharmacy: ________________ Phone: ______________ City or Zip Code: __________

Do you give permission for your PHI (protected health information) to be discussed with anyone other than yourself? Yes No

If yes, please list names here:

1. Name ______________________ Relationship to you ______________________
2. Name ______________________ Relationship to you ______________________

Do you have a healthcare proxy or someone who can make medical decisions for you if you are unable to yourself? Yes No

Primary Insurance: ________________ Policy ID #: ______________ Grp #: __________

Policy Holder: ________________ DOB: ___/___/___ Relationship to patient: __________

Secondary Insurance: ________________ Policy ID #: ______________ Grp #: __________

Policy Holder: ________________ DOB: ___/___/___ Relationship to patient: __________