

Intake and History Form

P Professional Dermatology Care, PC

Name: _____

Date: _____

Street Address:

City: _____

State:

Zip Code: _____

Date of Birth: ____/____/____

Gender: _____

**PLEASE GIVE US A NUMBER WHERE
WE CAN CONTACT YOU!**

Preferred Phone Numbers:

Alternative Phone Number:

PLEASE DON'T FORGET YOUR INSURANCE CARD! If you do forget it then of course, you can be seen but you'll have to pay out of pocket or reschedule. What a shame! It's just a card- try not to forget it.

PLEASE READ: Do not give us any other medical information! We will ask your medical information at the time of your visit.

Email Address:

Emergency Contact:

Preferred Pharmacy

Name:

Phone Number:

City or Zip Code:
