Professional Dermatology Care, PC

Intake Form

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

Date: ______/__________/___________

Name: ____

Street Address: ____City:____________________________

State: _______________ Zip: ________________ Date of Birth: __________/__________/___________

Phone Number: _____________________________ Alternative Number: ____________________________

Email Address: ____

Emergency Contact: __________________________________ Phone: __________________________________

Primary Care Physician: ___________________________________ Phone: ____________________________

Referring Doctor: ____ Phone: ____________________________

Pharmacy: _________________________Phone: ____________________City or Zip Code: ______________

Primary Insurance: ______________________ Policy ID #: _________________ Grp #: ______________

Policy Holder: ______________________ DOB: ___/___/____Relationship to patient: ________________

Secondary Insurance:_____________________ Policy ID #: _________________ Grp #: ______________

Policy Holder: ______________________ DOB:___/___/____Relationship to patient: _________________

PLEASE DON'T FORGET YOUR INSURANCE CARD!

Please be sure to bring your insurance card with you to EACH VISIT. If you do not have your insurance card, unfortunately, we will not be able to see you.