

Consulting Dermatologic Specialists
7777 Forest Lane Bldg C Suite 528
Dallas Texas 75230
(972) 566-4537 Fax (972) 566-6018

Patient Name: _____ Birthdate: _____

Our office will refer to this sheet when we attempt to contact you with medical information, diagnosis and results. Therefore, please be sure to list all telephone numbers where you may be reached and person(s) other than yourself we may speak to regarding your personal medical information, diagnosis and results.

Telephone Numbers you may be reached at:

May we leave a message on voicemail or answering machine. _____
Initial/Date

1. _____
2. _____
3. _____

Person(s) we may contact and discuss your personal medical information, diagnosis, and results:

1. _____	_____	_____
NAME	RELATIONSHIP	PHONE NUMBER
2. _____	_____	_____
NAME	RELATIONSHIP	PHONE NUMBER
3. _____	_____	_____
NAME	RELATIONSHIP	PHONE NUMBER

May we contact you by email? yes no if yes, email address: _____

My signature below indicates that I have received and/or reviewed a copy of my physician's Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices). I have been given the option of signing a separate Patient Consent Form.

PATIENT SIGNATURE

DATE

WITNESS SIGNATURE

DATE