REISENAUER DERMATOLOGY

internal use only		AMD		EMA		Rx Plan

PATIENT INFORMATION (please print)

Name: _____ Age: _____
(Last) (First) (MI)

Address: _____
(Mailing) (City) (State) (Zip)

Phone (check preferred): ☐ _____ ☐ _____ ☐ _____
(Home) (Cell) (Work)

Do we have your permission to leave a message regarding your medical condition and/or test results on an answering machine? ☐ Yes ☐ No

DOB: ____ /____ /_____ Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married

Email Address: _____

Check **ALL** that apply:

Preferred Language: ☐ English ☐ Spanish ☐ Other _____

Ethnicity: ☐ Decline to Specify ☐ Hispanic or Latino ☐ Neither

Race: ☐ Decline to Specify ☐ White ☐ Asian
☐ American Indian or Alaska Native
☐ Black or African American
☐ Native Hawaiian or Pacific Islander
☐ Other _____

Emergency Contact

Name: _____ Relationship: _____ Phone: _____
(If under 18, name of parent)

Pharmacy Name & Location: _____

Primary Care Physician: _____

Referring Physician: _____

All of the above is correct to the best of my knowledge, and I agree to notify this office in a timely manner of any changes.

Inital: _____

I hereby authorize Reisenauer Dermatology to access my filled prescriptions electronically using SureScripts.

Inital: _____

I authorize _____

phone _____

to be informed about my medical care, including biopsy results, lab and x-ray test results, prescriptions, and treatment plans.

Inital: _____

_____ ____ /____ / _____

Patient or Responsible Party Signature **(or type your full name)** **Date**