DARTMOUTH DERMATOLOGY ASSOCIATES, P.C.
368 Faunce Corner Road, Suite 2, Dartmouth, MA 02747
Patient Information

First, Middle, Last Name:_____

Street:_____

City:_____ State:_____ Zip:_____

Date of Birth:_____ Birth Gender:_____

Current Gender:_____ Email:_____

Home Phone:_____Cell Phone:_____

Race:_____Ethnicity:_____Language:_____

Emergency Contact Name:_____

Emergency Contact Relationship:_____

Emergency Contact Phone:_____

Primary Care Physician:_____

Primary Care Phone:_____

*******PLEASE PROVIDE ALL INSURANCE/ PRESCRIPTION CARDS TO THE SECRETARY*******

I apply for and consent to such medical and surgical treatment and diagnostic procedures as my provider MAY prescribe which meet my approval. I further authorize the release of medical information to my physician, or to such physicians or hospital departments to which the provider may refer me for care. I hereby authorize the provider to release any information acquired in the course of my treatment necessary to process insurance claims.

I understand that a summary of my visit will be provided to me upon my request. This Will be provided at the time of my visit should one be requested. I understand that this summary will only be provided in person or electronically.

My signature further agrees to allow the use of my e-mail address for any correspondence such as, but not limited to, appointment reminders, newsletters, and/or advertisement.

Signature:_____ **Date:**_____

Print name and relationship to patient:_____