Dermatology Professionals, LLC

Patient Information (please print)

Name: _____
Last First M.I.

Address:_____
Street Apt. # City State Zip

Telephone Home:_____ Cell:_____

Email Address:_____ DOB:_____ Marital Status: S M D W Sep

Employer:_____ Telephone (Work):_____

Preferred Language:_____**Ethnicity:** Hispanic/Non Hispanic/ *No Answer*

Race (Please Circle One): American Indian or Alaska Native / Asian / Black or African American
Native Hawaiian or Other Pacific Islands / White / *No Answer*

Pharmacy Name: _____ Pharmacy Location: _____

Primary Care Provider Name: _____ Number: _____

Emergency Contact :_____Relationship:_____ Phone:_____

Responsible Party (Person responsible for payment)
☐ **Same as above**
Name:_____Relationship: _____

Home Address:_____

Home Telephone:_____ Business Phone: _____

Primary Insurance
Insurance Name: _____ Co-Pay $:_____

Policy Holder/Subscriber Name: _____ Relationship: _____

Policy Holder DOB:_____ ID # _____Group or Plan# _____

Secondary Insurance (If applicable)
Insurance Name: _____ Co-Pay $:_____

Policy Holder/Subscriber Name (if different):_____ Relationship:_____

Policy Holder DOB:_____ ID # _____ Group or Plan# _____

Consent to Medical Care
In order to provide you with medical care, we need to have written consent from you Dr. Taylor will be happy to address any question or concerns you may have about your condition or treatment. I give my permission to Claudia Taylor, M.D., and staff, to administer treatment and to perform such procedures as may be deemed necessary in the diagnosis and treatment of my condition.

_____

Signature of Patient (or guardian) Date