WELCOME TO MADRONA DERMATOLOGY

NAME: ____

DOB: ____

PHONE NUMBER: ________________________________ **HOME WORK CELL**

OK TO LEAVE DETAILED MESSAGE? YES NO

ADDRESS: ____

PHARMACY (name, city, phone number):

____

PRIMARY CARE PHYSICIAN: ____

OFFICE ADDRESS / PHONE # OF PCP: ___________________________________

____

REFERRING PHYSICIAN: ____

DO YOU HAVE A LIVING WILL? ____

ARE YOU INTERESTED IN BOTOX, FILLERS OR A COSMETIC CONSULT?

(CIRCLE) YES NO

HAVE YOU EVER BEEN A PREVIOUS PT OF DR. DICK?

(CIRCLE) YES NO

EMAIL: ____

*** YOUR EMAIL ADDRESS WILL BE USED TO SET UP YOUR PATIENT PORTAL. WE ARE REQUIRED TO ACTIVATE YOUR PORTAL EVEN IF YOU CHOOSE TO NOT PARTICIPATE. ONCE YOU RECEIVE THE EMAIL FROM US, FOLLOW THE INSTRUCTIONS AND IT WILL ASSIST YOU IN GETTING STARTED. PLEASE CONTACT MADRONA DERMATOLOGY IF YOU HAVE ANY QUESTIONS OR DIFFICULTIES.**