Center for Skin & Cosmetic Dermatology
Phone: 817.921.2838 Fax: 817.921.2833
www.mytotalskincare.com

Patient Information

Patient Name (PRINT)	**Date of Birth** ____/____/____	M F *Circle* **Sex of Patient**	**Today's Date**

Address **Apt #** **City** **State** **Zip**

(please mark the box next to each phone number indicating whether or not the physician or staff may leave a message)

Home Phone ( ) _____-_____ Y N	**Work Phone** ( ) _____-_____ Y N	**Alt./Cell Phone** ( ) _____-_____ Y N	**EMERGENCY CONTACT #** ( ) _____-_____
Social Security Number	**Marital Status** *(please circle)* **M S W D Minor**	**Primary Care Physician**	**EMERG. CONTACT NAME**
Occupation	**Employer**	**E-mail Address**	

Who may we thank for your visit? ***(please circle and list)*** **Physician / Friend**

Please read and sign the following consent for examination and treatment:

I am at least 18 years of age, or, if not am accompanied by a legal guardian. I understand the need for such information contained herein to be updated annually. I understand that photography is at times a necessary part of planning and evaluating treatment, and hereby authorize the taking of photographs at the direction of the physician and/or delegate solely for documentation purposes and recognize they will be kept confidential unless otherwise disclosed. I understand I am ULTIMATELY responsible for payment of services rendered. I hereby give the physician/staff at Center for Skin & Cosmetic Dermatology, Malouf Dermatology, P.A., authorization for EXAMINATION and TREATMENT.

Signature	**PATIENT SPOUSE PARENT GUARDIAN** Relationship (*please circle*)	____/____/____ Date