HOUSTON DERMATOLOGY ASSOCIATES,P.A.

PATIENT NAME: ____

Do we have permission to:

Leave a message on your answering machine at home or voice mail? Yes No

Leave a message at your place of employment? Yes No

Discuss any medical condition with any member of your household? Yes No

If yes, who? ________________Relationship_______Contact number___________

If yes, who? ________________Relationship_______Contact number___________

Others authorized to receive information about your medical condition:

Name____________________Relationship_____________Contact number_____________

Primary care physician name and number _______________________________________

Please provide your pharmacy information (please include name,number,and address) All prescriptions are sent electronically.

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Signature:___________________________________ Date:_________________________