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Dermatology and Laser Institute of Colorado, P.C.

CONTACT INFORMATION: REQUIRED INFORMATION

Emergency Contact Name: _____ Phone Number:(_____)_____

Emergency Contact Address:_____

Pharmacy Name & Location:_____ Phone Number:(_____)_____

Primary Care Physician:_____ Phone Number:(_____)_____

Referring Physician Same as above:_____ Phone Number:(_____)_____

Other family members that are patients: _____

If you would like to be added to our **COSMETIC E-MAIL UPDATE LIST** to receive information alerts and special in-office cosmetic promotions, please provide your e-mail address:_____ No Thank You

RESULTS REPORTING

There may be certain circumstances that will require a skin biopsy or other lab work to be done. Please read the following consents and fill in appropriately.

I, _____ give the staff of the Dermatology & Laser Institute of Colorado, P.C., permission to leave results of any diagnostic or other lab test with the following individuals or phone numbers.

I authorize to be notified of my result/s at the following number: (_____)_____

I authorize messages with result/s to be left at the following number: (_____)_____

I authorize messages with result/s to be left with certain individuals at the following numbers:

Name of Person:_____ Relationship:_____ (_____)_____

Name of Person:_____ Relationship:_____ (_____)_____

I understand that I should typically hear from the office with the results in one week or less. I understand that I should contact the office directly if I have not received results within 1 week of the procedure. **I also understand that I should not assume the results are negative if I have not heard from the office.**

Signature of Patient or Legal Guardian

Date