



PATIENT INFORMATION FORM

PATIENT DATA

Last Name: _____ First Name: _____ Middle Initial: _____
Date of Birth: _____ Social Security: _____

PHONE

Home: _____ Preferred phone number: Home Mobile Work
Mobile: _____ Is it okay to leave a detailed message? Yes No
Work: _____

EMAIL

Email: _____ Are you interested in being contacted via email when we have promotional events? Yes No

ADDRESS

Address: _____
City: _____ State: _____ Zip: _____

EMERGENCY CONTACT

Name: _____ Phone: _____
Relationship to you: _____

GUARANTOR

Patient Relationship to the Guarantor: _____
Guarantor Last Name: _____ First Name: _____
Guarantor Home Phone: _____
Guarantor Gender: Female Male
Guarantor Address: _____
City: _____ State: _____ Zip: _____

REFERRAL

How did you hear about us? _____

I authorize Dr. Parrish Sadeghi and Pure Dermatology & Skin Surgery Center to contact me using the email address provided above (including my name, appointment reminders, information regarding my account balance, and instructions for accessing the patient portal). I understand that:

- The information is being sent for the purpose of communicating with me.
- The information could be viewed by anyone who has access to my email and that if my email is unsecured, the information could potentially be intercepted.
- This authorization will be in force and effective until I terminate my relationship with the practice or revoke the authorization by making a request in writing to: Pure Dermatology & Skin Surgery Center, 2001 Santa Monica Blvd St. 480W, Santa Monica, CA 90404.

Signature: _____ Date: _____

Please see other side 