DIXIE D. RICHARDS, M.D. Inc.
Diplomate, American Board of Dermatology
11633 San Vicente Blvd., Suite 310
Los Angeles, CA 90049

In order to serve you properly, we need the following information. All information will be confidential.

Date_____ ☐ Male ☐ Female

Patient Name _____ Birthdate _____

Address_____ City_____ State____ Zip_____

Check box ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Number (s) _____ _____ _____
Home phone Cell Phone Work Phone

Email Address_____

Patient's or parent's Employer _____

Business Address _____ City _____ State____ Zip _____

Spouse or parent's name _____ Employer _____

If patient is a student, name of school/college _____City_____ Zip_____

Whom may we thank for referring you? _____

When it becomes necessary to contact you by phone, please list the number(s) where you wish us to call. May we leave messages, such as labs results, appointments or other medical information on an answering device, or with another person who answers the phone at that number? ☐ Yes ☐ No

Where you want to be contacted ☐ Home ☐ Cell ☐ Work

Person to contact in case of emergency-not living with you _____

RESPONSIBLE PARTY

Name of person responsible _____ Relationship to patient_____

Address_____ Home phone _____

Birthdate _____ Employer _____Work phone_____