

Patient Demographic Information and Message Consent

First Name:		Middle Name:		Last Name:
Date of Birth:		Sex: Male / Female / Other		
Marital Status:	□Single □Marrie	arried □Divorced □Widowed □Other		
Address:				Apartment #:
City:		State:		Zip Code:
Cell Phone:		Home Phone:		Work Phone:
Email:		Preferred Method of Contact: Call Call		□Text □Email
Emergency Contact Name:		Phone #:		Relationship:
Preferred Pharmacy Name:			Pharmacy City:	
Primary Clinic:			Primary Doctor's Name:	
Referring Clinic:		Referring Provider:		
How did you hear about us? □ Provider Referral □ Word of Mouth □ Billboard □ Former Patient of Dr. Darabi □ Postcard □ Google □ Facebook □ Instagram □ Nextdoor Neighboor I authorize Darabi Dermatology to leave a detailed message with information about my health, test results, insurance and				
financial information as a voice message to the numbers I provided, as a secure text message to my cell phone, and via email to the email address I provided. Note, if you do not provide authorization we may play the famous game of 'phone tag' with each other:				
Signature:				te: