PATIENT'S INTAKE FORM

All records are confidential unless patient authorizes release.

Patient Information

First Name:	Middle Name:	Last Name:
Date of Birth (DOB):	Email: May we contact you via email? ☐ Yes ☐ No	

Address:	City:	State:	Zip:

Home Phone #: ☐ None	Work Phone#: ☐ None	Cell Phone#: ☐ None

Is it okay to leave a detailed message? ☐ Yes ☐ No

List other people in the household that we may leave messages with or discuss medical conditions with:

Occupation

Please list your occupation:

Emergency Contact

In case of emergency, please contact:

Emergency Contact Phone #:	Relationship:

Primary Care Provider Information ☐ None at time of intake ☐ Obtained from eCW

First Name (required):	Last Name (required):	Phone:	
Address:	City (required):	State (required	Zip:

Specialist Provider Information ☐ None at time of intake ☐ Obtained from eCW

First Name (required):	Last Name (required):	Phone:	Specialty:
Address:	City (required):	State (required):	Zip:

Pharmacy ☐ None at time of intake ☐ Obtained from eCW

Which pharmacy would you like us to call a prescription in to?

Location (City and State):	Phone # (if available):

Do you wish to opt-in to marketing SMS (text messages) for information related to future research trial opportunities at Oregon Dermatology and Research Center? ☐ Yes ☐ No

If yes, you will have the opportunity to opt-in or opt-out at anytime by notifying us via SMS reply or calling 503-226-3376. Text messages will be sent at no cost to you, however, please check with your cell phone carrier as the cost to receive text messages vary by wireless provider and service contracts. Oregon Dermatology and Research Center does not sell or share your information for marketing purposes.

I certify that the information in this Patient Intake Form is true:

Participant OR parent/guardian signature: _____ Date: _____