

Dawes Fretzin Dermatology Group

In order to better coordinate and communicate your care with your primary care physician, please complete the following information:

Patient Name: \_\_\_\_\_

Primary care physician: \_\_\_\_\_

Did a physician specifically refer you to our office for **this visit** or problem?

Yes\_\_\_\_ No\_\_\_\_

**If yes**, what is the name of the referring physician **if different** than your primary care physician?

\_\_\_\_\_

In a **few simple** words, please identify the problem to be evaluated (i.e. acne, rash, mole, history of skin cancer, etc...):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Thank you!