



Patient Agreement Form

Name: _____ Age: _____ DOB ____/____/____ SS# _____

Address: _____

Street

City

State

Zip Code

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Marital Status (circle one): Married Divorced Single Widowed

Employer _____ Occupation: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Numbers: _____

Email: _____

Pharmacy Information _____

How did you hear about us: _____

I consent for treatment by the Physicians of Johns Creek Dermatology & Family Medicine, as well as, I agree to allow the Physician to diagnose and treat my condition based on their extensive knowledge and recommendation pertaining to my medical condition. _____ (Patient Initials)

I acknowledge that all information supplied by myself to Johns Creek Dermatology & Family Medicine is true and correct. _____ (Patient Initials)

*Signature: _____ Date: _____