PHOEBE RICH DERMATOLOGY
Oregon Dermatology & Research Center

PATIENT INTAKE FORM

All records remain confidential unless patient authorizes release.

Patient Information (Required)

First Name:	Middle Name: ☐ None	Last Name:		
Date of Birth (Month/Day/Year):	Email:	May we contact you via email? ☐ Yes ☐ No		
Sex at Birth: ☐ Male ☐ Female	Gender: ☐ Prefer not to answer	Pronouns: ☐ Prefer not to answer	Race: ☐ Unknown ☐ Prefer not to answer	Ethnicity: ☐ Unknown ☐ Prefer not to answer
Address:	City:	State:	Zip:	
Cell Phone #: ☐ None	Home Phone #: ☐ None	Work Phone #: ☐ None		
Is it okay to leave you a detailed message? ☐ Yes ☐ No	Who else in your household may receive messages or discuss your care? ☐ None			
Occupation: ☐ N/A				

Emergency Contact ☐ None at time of intake

In case of emergency, please contact (required):	
Emergency Contact Phone # (required):	Relationship (required):

Primary Care Provider Information ☐ None at time of intake

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

Specialist Provider Information ☐ None at time of intake

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

Pharmacy ☐ None at time of intake

Name of Pharmacy (required):	
Location - City and State (required):	Phone #:

Future Trial Opportunities (Required)

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

If Yes, you will have the opportunity to opt-in or opt-out at anytime by notifying us via SMS, EMAIL, 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. Please note that if you applied online, you have already opted into SMS marketing.

I certify that the information provided on this form is true and accurate to the best of my knowledge.

Patient or Parent/Guardian Signature: _____ **Date:** _____