



www.VitalogySkincare.com
Skin Cancer and Dermatology Centers

Vitalogy

SKINCARE

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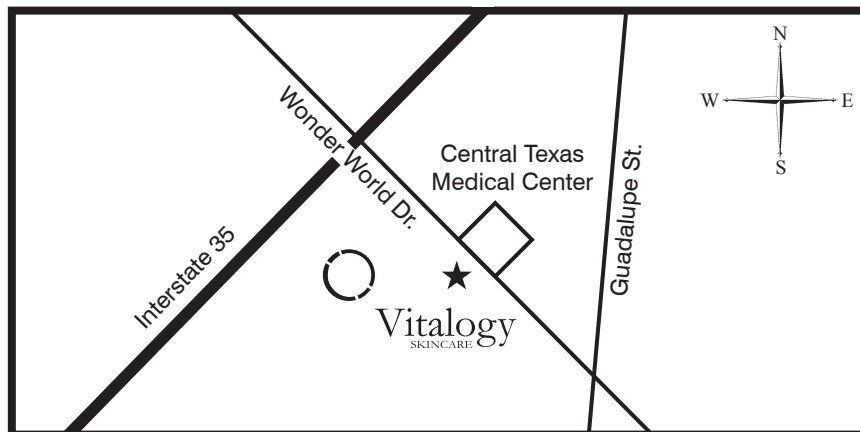
PHYSICIAN CONSULTATION

Patient's Name _____ Date: _____

Referring Physician _____ Phone _____

- | | | | |
|-------------------|--------------------------------------|---|---|
| Reason for Visit: | <input type="radio"/> Acne | <input type="radio"/> Hair/Nail Disorder | <input type="radio"/> Cosmetic |
| | <input type="radio"/> Rash | <input type="radio"/> Mole | <input type="radio"/> Wart |
| | <input type="radio"/> Athlete's Foot | <input type="radio"/> Pigmentation disorder | <input type="radio"/> Skin Cancer Biopsy |
| | <input type="radio"/> Dermatitis | <input type="radio"/> Skin lesion | <input type="radio"/> Skin Cancer Treatment |
| Other/Details: | (Excision or Mohs Surgery) | | |

*Please fax any patient records or biopsy results pertaining to the referral to our office at 512.754.3378
The providers of Vitalogy Skincare are participating providers for all major insurance carriers.



Appointment Date: _____

Appointment Time: _____

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