AFFILIATED DERMATOLOGISTS & DERMATOLOGIC SURGEONS

PATIENT PORTAL ENROLLMENT FORM

Due to Federal Regulations, our practice is required to ask you to enroll in our Patient Portal. The Portal is a secure website that will allow us to communicate with you regarding your ongoing health management.

In order to access the Portal, we need your e-mail address. Please rest assured our office will not use your e-mail address for any reason other than to communicate with you regarding your care.

If you have further questions about the Portal, please feel free to ask a member of our staff.

Today's Date: _____ Birthdate: _____

Patient Name: _____

E-Mail Address: _____

Please enroll me in Affiliated Dermatologists' Patient Portal.

Patient Signature: _____

FOR OFFICE USE ONLY

Patient's Account # _____ Employee's Name: _____