

Specialist Referral To:

South Charlotte Dermatology, PC
David B. Schulman, M.D., F.A.A.D.
10370 Park Road, Suite 201, Charlotte, NC 28210 704-542-3003

Date: _____

➔ ➔ ➔ ➔ ➔ Fax Referral to: 704-542-3040 ← ← ← ← ←

Please attach a copy of the insurance card if you have it.

Appointment Hours:	Monday through Wednesday	8:00 am – 4:45 pm
	Thursday	8:00 am – 6:30 pm
	Friday	No Appointments (Office Open 9:00 am – 1:00 pm)
	Saturday (2 per month)	Please Call First (8:00 am – 1:00 pm)

➔ Referring Physician Name:

Phone:

Reason for Referral

- **Growths**
 - New
 - Change in Mole
 - **Rash**
 - Medication
 - Eczema
 - **Skin Cancer**
 - Family History
 - Personal History
 - **Abscess/Boil**
 - Duration
 - **Rosacea**
 - Inflammatory
 - **Acne**
 - Cystic
 - **Miscellaneous**
 - Warts
 - Private Matter
- | | | | |
|---|--|--|-----------------------------------|
| <input type="checkbox"/> Suspicious | <input type="checkbox"/> Itch | <input type="checkbox"/> Painful | <input type="checkbox"/> Bleeding |
| <input type="checkbox"/> Zoster | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Soreness | |
| <input type="checkbox"/> Fungal | <input type="checkbox"/> Seborrheic Dermatitis | <input type="checkbox"/> Contact | |
| <input type="checkbox"/> Basal Cell | <input type="checkbox"/> Squamous Cell | <input type="checkbox"/> Melanoma (Date/Depth/Nodes) | |
| <input type="checkbox"/> Prior Treatment | <input type="checkbox"/> Antibiotics | | |
| <input type="checkbox"/> Acneiform | <input type="checkbox"/> Cystic | | |
| <input type="checkbox"/> Non-Cystic | | | |
| <input type="checkbox"/> Molluscum | <input type="checkbox"/> HPV | <input type="checkbox"/> Venous Disorder | |
| <input type="checkbox"/> Other (Please Explain) | | | |
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Patient Demographics

Full Name: _____ Male Female
Address: _____ Date of Birth: _____
SS#: _____ Phone: _____
Is the Patient the Guarantor? Male Female
Guarantor Name: _____ Phone: _____
SS#: _____ Cell: _____

Insurance Information

Name of Primary Insurance: _____
Subscriber: _____ DOB: _____ Claims Address: _____
ID#: _____ Group#: _____
Relationship to Pt: Self Spouse Child

Appointment Preference

First Available Appointment Date: _____ Time: _____

➔ Once the appointment is made, please fax back to: _____ Fax #: _____