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

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 #:**

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