Virtual Appointment Request with Dr. ____________________ for concerns of ___________________

____

<u>Demographic Information</u>

First and Last Name: ____

Phone Number (home/cell):____

Street Address: ____

City, State & Zip Code: ____

Email: ____

FOR MEDICARE PATIENTS ONLY, Medicare ID #: _______________________________________

By signing, I acknowledge that I am not a Medicare patient and I am agreeing to pay the $75.00 out-of-pocket cost associated for this virtual appointment.

Sign: ____

History of Present Illness/ Concern:

____

Area affected: ____

When did it start/ first appear? ____

How long has it been present? ____

What symptoms are you experiencing? ____

Do you have any photos attached to this email? ______________________________________

If so, please attach.