Comprehensive Rheumatology Center

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Name: _____ Date of Birth: _____

Telephone: _____ Secondary Telephone: _____

Address:
_____
Street City Zip Code

**Email:_____

Pharmacy (Name, City, Telephone): _____

Specialty Pharmacy (If required by insurance): _____

Primary Physician: _____ Referring Physician:_____

Race: _____ Ethnicity: _____ Language: _____

Emergency Contact:

1) Name: _____ Telephone: _____

2) Name: _____ Telephone: _____

***Please Note:** We request your email address only for our Online Patient Portal. With the patient portal you can view lab results and upcoming appointments. Also, schedule and change future appointment. The most important feature of our portal is you can send messages directly to the providers and staff.