



**PATIENT INFORMATION FORM  
For First Time Purchase of Prescription-Only Products**

***Please have your healthcare provider sign on the back where indicated***

**Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Name of patient:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Mailing Address:** \_\_\_\_\_  
\_\_\_\_\_

**Home Phone:** (        ) \_\_\_\_\_

**Cell Phone:** (        ) \_\_\_\_\_

**Email Address:** \_\_\_\_\_

Prescription medication(s) I am interested in ordering from The Web Dermatologist:

- Latisse® for eyelashes**
- Tretinoin Cream (generic equivalent to Retin A®)**
- Hydroquinone 4% Cream for hyperpigmentation (sun spots & freckles)**
- Metronidazole Cream for rosacea**

*We will need to review your medical history to be sure the medication you are ordering is safe for you to use. Please complete the medical history form below:*

**No, I am NOT currently pregnant, breast feeding, or planning on getting pregnant while using these medications. (Please initial) \_\_\_\_\_**

**Consent to Treat: With respect to the medication I am ordering from TheWebDermatologist.com, I consent for you to treat me as one of your patients. (Please initial) \_\_\_\_\_**

**Are you allergic to any medications? \_\_\_\_\_Yes \_\_\_\_\_No**

**If yes, please list:** \_\_\_\_\_

**Please list all pills, medicines or tablets you are taking:** \_\_\_\_\_  
\_\_\_\_\_

(2)

**Please list any other medical conditions for which you are being treated:**

---

**Is there anything else we should know about your health? \_\_\_\_Yes \_\_\_\_No**

**If yes, please list:** \_\_\_\_\_

***Please take this form to your Primary Care Provider (Physician or Physician Assistant or Nurse Practitioner) for them to sign below and then you may fax (802-660-4310) or mail it to our office.***

"I agree that I have an ongoing relationship with the above mentioned patient and agree to supervise their treatment related to the use of any of the above listed prescribed medications."

\_\_\_\_\_  
Healthcare provider signature

\_\_\_\_\_  
Please print name

**Please fax this form to The Web Dermatologist at 802-660-4310  
or mail it to our Dorset Street Dermatology office at  
325 Dorset Street, South Burlington, VT 05403**

Mitchell Schwartz, MD  
Diplomate, American Board of Dermatology  
325 Dorset Street  
South Burlington, VT 05403  
802-660-8808  
800-946-8808