JAMES D WETHE, MD

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PATIENT INFORMATION

Name

Address | City | State | Zip Code

Home # | **Cell #** | **Work** #

Date of Birth | *E-mail Address

Primary Care Physician | Phone/Fax #

Emergency Contact | Relationship | Phone #

Referral Source ☐ **Family/Friend** ☐ **Website** ☐ **Social Media** ☐ **Yelp** ☐ **Skin365**

OK to contact? ☐ Home ☐ Cell ☐ Work ☐ Emergency Contact

Signature | Date

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