

Please select this box for urgent cases and same-week scheduling

Revised December 2025



Please fax this General Dermatology Form to 205.930.1750

Date:

Patient Name:

Patient DOB:

Parent or Legal Guardian (if applicable):

Phone Number:

Email:

Mailing Address:

City:

State:

Zip Code:

Primary Insurance:

Insurance Provider

Policy #

Group #

Secondary Insurance:

(If applicable)

Insurance Provider

Policy #

Group #

Does Insurance require a Referral/Authorization:

If yes, please include the referral/authorization with this form.

YES

NO

Reason(s) for Referral/Consult:

Note: Please indicate either a specific provider and/or location preference. Please note that all Total Dermatology providers do not see patients at all locations.

PROVIDER REQUEST:

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Sara Hopper, CRNP
FIRST AVAILABLE

LOCATION REQUEST:

Main Office-Downtown Birmingham
Trussville
Gardendale
McCalla
FIRST AVAILABLE

Primary Care Provider:

NPI:

Referring Provider:

NPI:

Sent by (person sending form):

of page (including cover sheet):

Referring Office Phone Number:

Fax Number:

Please include past clinic notes and all applicable labs with this referral

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