



1952 Field Rd Sarasota, FL 34231  
www.dermatologyexperts.com

941.926.7546

Patient <b>Legal</b> Name (First, Middle, Last)		Date of Birth	Age	Sex	Social Security Number (REQUIRED)
Primary Address		City	State	Zip	Home ( ) Cell ( ) Work ( )
Summer Address		City	State	Zip	Home ( )
Legal Guardian / Power of Attorney (if minor or applicable)				Marital Status: <input type="checkbox"/> single <input type="checkbox"/> married <input type="checkbox"/> divorced <input type="checkbox"/> widowed	
Emergency Contact		Relationship		Emergency Contact Number	

Uninsured method of payment: <input type="checkbox"/> Cash <input type="checkbox"/> Credit (Visa, Amex, Mastercard)			
<b>Primary Insurance:</b>		<b>Secondary Insurance:</b>	
Subscriber ID:	Insured's Name:	Subscriber ID:	Insured's Name:
Relationship to patient:	Date of Birth:	Relationship to patient:	Date of Birth:
Employer:	<b>Name of Referring Physician:</b> Phone:		
<b>Name of Primary Care Physician:</b>		Phone:	Fax:

<b>How did you hear about our office?</b> <input type="checkbox"/> <b>Doctor</b> _____ <input type="checkbox"/> <b>Patient</b> _____ (Please check all that apply) <input type="checkbox"/> Internet <input type="checkbox"/> Phone Book <input type="checkbox"/> Newspaper <input type="checkbox"/> Magazine <input type="checkbox"/> Staff <input type="checkbox"/> other: _____
<input type="checkbox"/> Yes, I would like to receive occasional O'Donoghue Dermatology news and service/product updates. (We do not sell, share, rent, or disclose your information. By checking the box, you give us permission to add you to our mailing list.)
EMAIL Address: _____

I certify that the information I provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare), for the purpose of filing and payment of medical claims. I authorize payment of medical benefits to O'Donoghue Dermatology.

**I understand that my insurance is a contract between my insurer and myself. I am responsible for understanding the terms of my policy, including deductibles, co-pays, co-insurances and referrals. I am responsible for obtaining any required referrals, and in absence of such, I will be held responsible for the cost of service provided.**

Payment is required for all services at the time they are rendered. **All applicable co-payments and deductibles will be collected at the time of service.** Our terms are net 30 days. Appointments that are cancelled 24 hours prior to the appointment time or not attended may be charged a \$50 fee. Your signature below signifies your understanding and willingness to comply with this policy.

Patient Signature: _____	Date: _____
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I, the undersigned, hereby consent to medical treatment. In addition, I give permission to have a biopsy(s), minor surgical procedures and any subsequent treatment as deemed necessary as long as the risks and complications are discussed with me prior to the procedure. Some risks/side effects include: pain-during and after the procedure, bleeding, infection, light-headed/fainting, scars (possible disfiguring), hyperpigmentation, hypopigmentation, recurrence (re-growth) of the lesion being treated, and nerve injury with loss of nerve or muscle function.

I understand that any pathology and/or laboratory fees that are billed independently of O'Donoghue Dermatology are ultimately the patient's responsibility.

Patient Signature: _____	Date: _____
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