O'DONOGHUE DERMATOLOGY

1952 Field Rd Sarasota,FL 34231 *941.926.7546*
www.dermatologyexperts.com

Patient **Legal** 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: ☐single ☐married/partnered ☐divorced ☐widowed

Emergency Contact	Relationship	Emergency Contact Number

Uninsured method of payment: ☐Cash ☐Credit (Visa, Amex, Mastercard)

Primary Insurance:		**Secondary Insurance:**	
Subscriber ID:	Insured's Name:	Subscriber ID:	Insured's Name:
Relationship to patient:	Date of Birth:	Relationship to patient:	Date of Birth:

Employer:	**Name of Referring Physician**: Phone:

Name of Primary Care Physician:
Phone: Fax:

How did you hear about our office? ☐**Doctor**_____ ☐**Patient**_____
(Please check all that apply)
☐Internet ☐Phone Book ☐Newspaper ☐Magazine ☐Staff ☐other:_____

☐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 $75 fee. Your signature below signifies your understanding and willingness to comply with this policy.

Patient Signature: Date:

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: