



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

941.926.7546

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: <input type="checkbox"/> single <input type="checkbox"/> married/partnered <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)			
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? <input type="checkbox"/> Doctor <input type="checkbox"/> Patient
(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 \$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: