ORMOND BEACH DERMATOLOGY
PATIENT REGISTRATION

Sex M F

_____ _____ _____
LAST FIRST MIDDLE

Nickname: _____ SS # _____ DOB _____ _____ _____
MONTH DAY YEAR

Mailing Address _____ _____ _____ _____ _____
STREET ADDRESS APT # CITY STATE ZIP

Phone Number _____ _____ _____
Preferred Secondary

Email address: _____

If patient is under age 18:

Father's Name_____Address:_____Phone#:_____

Mother's Name_____Address:_____Phone #:_____

All patients <u>MUST</u> present copy of photo i.d. and proof of current insurance coverage. If this information is not provided we will ask you to reschedule your appointment and return with this information <u>OR you may pay for your visit in full as an out-of-pocket visit</u>.

Do we have permission to:

Leave a voicemail regarding appts or to return our call? ☐ **YES** ☐ **NO**

Email/Mail promotional information to you? ☐ **YES** ☐ **NO**

Discuss medical condition/leave message with anyone other than patient? ☐ **YES** ☐ **NO**

If yes, whom? _____ **Relationship** _____ **Phone #** _____

Name of Primary Care Physician: _____

- **Medicare patients who are currently employed please list employer** _____
- **Payment is due in full at time of service for all self-pay, cosmetic and elective procedures.**
- **Cosmetic procedure packages must be paid for in full at time of first treatment. No cash refunds will be given.**
- **Products may be exchanged within 30 days of purchase. No cash refunds will be given.**
- **Patient is responsible for insurance co-pays, coinsurance, and deductibles at time of service.**
- **Patient is responsible for knowing if we participate in your insurance plan.**
- **OBD will file your claim as a courtesy with primary and secondary companies *only*.**
- **You may receive a separate bill from laboratory when biopsies or excisions are performed.**
- **If patient is under 18, legal guardian is responsible for payment of account.**
- **Failure to cancel an appointment within 24 hours or No Shows may result in a fee assessed to account.**
- **If you arrive late for your appointment, you may be asked to reschedule.**
- **Delinquent accounts and returned checks may be referred to collections and fees may be assessed.**

I have read and understand the above policies. I assign my medical benefits to Ormond Beach Dermatology. I also authorize the release of my medical information to other physicians if needed and as necessary to process my insurance claims and prescriptions. I have had the opportunity to review OBD's HIPAA Notice of Privacy Practices. I may request a copy to keep if desired.

X_____ _____

Patient or Legal Guardian/Parent Signature **Date**