

# ORMOND BEACH DERMATOLOGY

## PATIENT REGISTRATION

Sex  
 M  F

\_\_\_\_\_  
LAST FIRST MIDDLE

Nickname: \_\_\_\_\_ DOB \_\_\_\_\_  
MONTH DAY YEAR

Mailing Address \_\_\_\_\_  
STREET ADDRESS APT # CITY STATE ZIP

Phone Number \_\_\_\_\_  
Preferred Secondary

Email address: \_\_\_\_\_

If patient is under age 18 please complete below:

Father's Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name of Primary Care Physician: \_\_\_\_\_

**All patients MUST present copy of photo ID 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 OR you may pay for your visit in full as an out-of-pocket visit.**

**BEST TELEPHONE NUMBER TO LEAVE A MESSAGE** \_\_\_\_\_

Email information to you?  YES  NO

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

\*If yes, whom? \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

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