PATIENT INFORMATION   Date:________

Last Name: ____________________   First: __________________   Middle Int ______
S.S. # _______________________   Date of Birth: __________ Sex □ Male □ Female
Martial Status □ Single   □ Married   □ Divorced   □ Widowed   □ Other
Address: ____ Apt#: ____________
City: ____________________________ State : __________ Zip code: _____________
Email: _______________________________
Do you have an alternate address or P.O. Box? □ Yes □ No
If yes, please print here: ____
Telephone Numbers: Home: _________________________ Work: ________________
Cell: ___________________________ Other: ______________
Employment Status: □ Full- Time □ Part-Time □Retired □ Other Occupation: ______
Employer: ____
Employer Address: ____
Are you a student? □ Yes □ No If yes, please check one: □ Full- Time □ Part-Time
Spouse/Parent Name: _______________________________
S.S.# ___________________________ Date of Birth: __________________________
Emergency Contact's Name: _________________________ Phone #________________
Their Relationship to You: _________________________________

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INSURANCE INFORMATION

Primary Insurance Company : _____________________________________
Are you the primary Insured: □ Yes □ No If not, please fill out the following:
Primary Insured's Name: _________________________ Date of Birth: ___________
S.S.# ___________________________ Relationship To Patient: _________________
Secondary Insurance Company : ____________________________________
Are you the primary insured: □ Yes □No If not, please fill out the following:
Primary Insured's Name: ________________________ Date of Birth ___________
S.S.#: ___________________________ Relationship to Patient: ________________

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MEDICAL INFORMATION

Reason for visit: ____
Have you received recent treatments for your current condition? □ Yes □No
Number of visits to a Dermatologist this year: ____________
List of current medications you are taking: _____________________________________
____
Any known allergies to drugs: ____
Other medical problems: ____
____

Have you ever had skin cancer? □ Yes □ No
Has any one in your family had skin cancer? □ Yes □ No

PRIMARY CARE INFORMATION

Name of Primary Care Physician: ____________________________________

Phone Number: _________________________ Fax Number: _____________________

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AUTHORIZATIONS

I hereby authorize direct payment of surgical/medical benefits to Orlando Dermatology, Inc. for services rendered by Dr. F. Lateef and/or employees under his supervision. I understand that I am financially responsible for all balances not covered including cosmetic services.

Patient/Guardian Signature: _____________________________________

Patient/Guardian Name (Please Print) ____________________________

We require your signed consent in order for us to provide any medical information about you to anyone other than one of your healthcare providers or your medical insurance company in regards to appointments, medical information such as biopsy results, bills, etc. Please sign the following statement:

I, _____________________________________, hereby grant permission to the physicians or staff of Orlando Dermatology Inc, to release related to my condition to any of the following individuals.

NAME	RELATIONSHIP
__________________________	____________________
__________________________	____________________

NOTICE OF PRIVACY PRACTICES:

As per HIPPA Privacy Rules, **please sign this form after reading the policies in the office.**

Signature: _____________________________________ Date: ___________________

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MEDICARE PATIENTS ONLY

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payer if they require if for the proper consideration of a claim. Please read and sign the following:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries to carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and requested payment of medical insurance benefits either to myself or the party who accepts assignment. Regulation pertaining to Medicare assignment of benefits applies.

Signature: _________________________________ Date: ________________________

FINANCIAL POLICY

We committed to providing you with the best possible care. If you have medical insurance, we will help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of your payment policy.

Please be aware that it is your responsibility to know your insurance policy, benefits and coverage in relation to Dermatologists. We do not acknowledge responsibility for each individual plan.
Co-payments and deductibles must be paid at the time services are rendered. No exceptions will be maid.
Patients with deductibles will be charged a standard fee. Once your insurance has processed the claim, the allowable of your insurance will be applied to the deductible. In case of an over payment, you may request a refund. Refunds will take form 30 to 45 business days once the Explanation of Benefits (EOB) has been received. In case of an underpayment, our practice will send you a bill shortly after the EOB has been received.
New patients with medical insurance must present their insurance cards on their first visit. Effective picture I.D. must also be provided.
Uninsured patients must pay the cost of the office visit before they are seen by the Doctor.
Payment for cosmetic procedures must be made before the procedure is performed. An establishing patient must notify the front desk in writing of any change, you will be responsible for all charges.
Any change of address should also be notified to the front desk in writing by filling our "change of address form."
Patients scheduled for appointments may reschedule or cancel the appointment no later than 24 hours before the scheduled date and time. You must speak to an office staff to cancel or reschedule the appointment. If the appointment is not cancelled or rescheduled at least 24 hours before, a $25.00 cancellation fee is charged.
If you have a surgery scheduled and you miss your appointment or cancel less than 24 hours there will be a $50.00 charge. No exceptions will be made.
Returned checks are subject to $30.00 charge. Unpaid accounts that are more than 60 days old will be sent to a collection agency after due notice is served to the patient with all fees payable by patient.

I have read the Financial Policy of Orlando Dermatology and agree to comply with its terms.

Patient Signature: ___________________________________ Date: _______________
Print Name: ______________________________________

Patient's Name: ____
First Last

I came here because (please check one)

☐ I was told to come here by my primary care doctor's office. (Referred)

☐ I came on my own without being told to come. (Not referred)

Patients Signature: __________________________

FOR OFFICE USE ONLY [DO NOT WRITE IN THIS BOX]

Status of referral sheet:

☐ Lost /misplaced by patient

☐ was never given to patient

☐ Attached (view below)

PCP: ____