www.burnettdermatology.com

1545 Mound Street Sarasota, Florida 34236 941~957~3376

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 Phone 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? (Please check all that apply) ☐ **Physician Referral** _____ ☐ **Patient Referral** _____

☐ **Internet** ☐ **Phone Book** ☐ **Newspaper** ☐ **Magazine** ☐ **Staff** ☐ **Other:**_____

☐ **Yes, I would like to receive occasional Burnett 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 *Burnett Dermatology* (S. Mark Burnett, MD, PA).
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 Burnett Dermatology (S. Mark Burnett, MD, PA) are ultimately the patient's responsibility.

Patient Signature: _____ **Date:** _____