Palm Beach Dermatology
Oren Lifshitz, M.D.
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Palm Beach Gardens, FL 33410

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Patient Registration Form

Patient Name:_____Date of Birth:_____Age _____

Local Address: _____
Street City State Zip

Home Phone ( )_____ Cell ( ) _____Work ( ) _____

Out of Town Address: _____ Out of Town Phone ( ) _____
Street City State Zip

Social Security #: _____

Marital Status ___S___M___W___D___Sep Spouse Name_____Birthdate _____

Occupation: _____

Employer's Address: _____ Phone ( ) _____
Street City State Zip

In Case Of Emergency Contact:_____Phone ( )_____Relationship _____

Other Family Members Who Are Patients: _____

Referred By: _____
Physician, Friend, Relative, Other

Primary Care Physician: _____

Address: _____ Phone ( ) _____
Street City State Zip

Pharmacy of Choice:_____ Phone ( ) _____

Insurance

Name of Insured: _____ Social Security # or Id #: _____

Name of Insurance: _____ Phone ( )_____Group #: _____

Address of Insurance Company: _____
Street City State Zip

If Student: _____Full Time ____Part Time Name of School _____

Insured's Responsibility: It is understood that services rendered by the doctor are to the patient, not to the insurance company, and that the patient and the undersigned are responsible for the payment of such services. It is not the responsibility of the doctor to collect from the insurance company.

PPO PATIENTS: I understand that if my insurance company refuses to pay for services rendered because they feel the services are not medically necessary or is pre-existing, that I am responsible to pay the balance in full promptly.

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. All "Insufficient Funds" checks are subject to a $30 service charge. In consideration of any services rendered by Oren Lifshitz, M.D. or associated health care provider, I agree to be responsible for the payment of all services notwithstanding any insurance coverage I may have. If it is necessary for Oren Lifshitz, M.D. to employ anyone, including attorneys, to collect such payments, then I shall be responsible to pay reasonable fees and costs, as well as a $25 surcharge, in addition to said payment.

I certify that the information given by me in applying for payment is correct. I authorize any holder of medical or other information about me to release to any referring physician, consultants as needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to Oren Lifshitz, M.D.

Patient or Responsible Party Signature _____Date_____