MARGARET O'NEILL, M.D.
Dermatology

PATIENT INFORMATION					
First Name		M.I.	Last Name		
Street Address			City		State
Zip Code	Home Phone #	Work Phone #	Cell Phone #	Social Security # - -	
Birth Date	Age	Sex (circle one) F M	Race	Marital Status	Spouse's Name
Patient's Employer	Patient's Occupation	E-mail Address			
Work Address	City	State	Zip Code		

RESPONSIBLE PARTY (IF OTHER THAN PATIENT)					
First Name		M.I.	Last Name		
Street Address			City		State
Zip Code	Home Phone #	Work Phone #	Cell Phone #	Social Security # - -	
Employer	Work Address	City	State	Zip Code	

INSURANCE INFORMATION				
Primary Insurance Company	Claims Address	City	State	Zip Code
Identification/Member Number	Group/Account Number	Subscriber's Name	Subscriber's Date of Birth	
Secondary Insurance Company	Claims Address	City	State	Zip Code
Identification/Member Number	Group/Account Number	Subscriber's Name	Subscriber's Date of Birth	

Who may we thank for referring you to our office?	**Please tell us the name of your primary/referring physician:**

PLEASE NOTE: ALL SCHEDULED APPOINTMENTS IN WHICH NOTIFICATION OF CANCELLATION IS NOT MADE AT LEAST 24 HOURS PRIOR TO APPOINTMENT TIME; YOU WILL BE CHARGED A FEE OF $50.00. FOR SURGICAL AND COSMETIC APPOINTMENTS, THIS FEE INCREASES TO $100.00 DUE TO THE LENGTH OF TIME SET ASIDE FOR THESE APPOINTMENTS. EXCEPTIONS WILL BE MADE ONLY IN THE CASE OF AN EMERGENCY, AND AT THE DISCRETION OF THE OFFICE MANAGER. PLEASE SIGN BELOW AS ACKNOWLEDGEMENT OF THIS POLICY.

Signature: ______________________________ Date: ____________________

PAYMENT IS DUE AT TIME OF SERVICE, WE ACCEPT:
VISA, MASTERCARD, DISCOVER or EXACT CASH!