SHERRI PEACE M.D.

PATIENT REGISTRATION FORM

Please print clearly and sign below

Date:_____ **Driver's Lic. #** _____

Last Name:_____ **First Name**:_____ **M.I**._____ **Suffix:**_____

DOB:_____ **Sex**:_____ **Home Address**:_____

City:_____ **State**:_____ **Zip**:_____ **SSN**:_____

Home No. (_____)_____ **Cell No.** (_____)_____ **Work No.** (____)_____

E-Mail_____

Primary Language:_____ **Language Spoken at Home**:_____

Employer:_____ **Occupation**:_____ **Address**:_____

Pharmacy:_____ **Address:**_____ **Phone No**. (____)_____

Referring MD:_____ **Address**:_____ **Phone No.** (____)_____

Marital Status: Single / Married / Divorced / Widowed / Separated / Other / Minor Child

Name of Parent:_____ **DOB:**_____ **Address:**_____

City:_____ **State:**_____ **Zip**:_____ **SSN**:_____

In Case of Emergency Contact: _____ **Address:**_____

City:_____ **State**:_____ **Zip**:_____ **Phone No:** (____)_____

Insurance Information (Please Complete)

Primary Insurance: _____ **Policy ID No**._____

Secondary Insurance: _____ **Policy ID No**. _____

-All professional services are the ultimate responsibility of the patient

Patient Signature: _____ **Date:** _____

It is important that this registration form is completely filled out with the patient's correct and most recent information. Please submit your insurance card(s), authorizations/referrals, (if applicable) with this form. Please pay all co-payments, deductibles, or if you are cash patient, upon arrival to our office visits. Thank you for visiting our office here at Westchester Dermatology Medical Clinic!!!!!

-I have been informed of the $25.00 cancellation fee:_____