Patient Registration Form

Patient Information

Title	*First Name	Middle Name	*Last Name (as it appears on insurance card or ID)	Suffix

Sex	*Date of Birth and Age	Marital Status	Referred By:

*Street Address	*City	*State	*Zip

*Home Phone	*Mobile Phone	Email Address

Medical Information

Primary Care Physician	PCP Phone Number	PCP Fax Number

PCP Address	City	State	Zip

*Pharmacy Name	*Pharmacy Number	Pharmacy Address

Employer/School Information

Employer/School Name	Employer/School Phone	Occupation

Employer/School Address	City	State	Zip

Emergency Contact Information

*Emergency Contact Name	*Emergency Contact Number	*Relation to Patient

Billing and Insurance

Primary Health Insurance

Insurance Company	Plan Name	Subscriber ID Number	Group Number

Responsible Party- if other than patient

Billing Name	Phone	Relation to Patient and Date of Birth

Address	City	State	Zip

*Information required

Cancellation Policy

Due to Dr. Clark's limited availability, a non-refundable cancellation fee of $35 for medical visits or $65 for cosmetic visits will be charged to the patient's account if the office is not provided with at least a 48 hour notice.

_____ _____

Signature of Patient or Authorized Guardian Date

Sheryl D. Clark, M.D.
109 East 61st Street
New York, NY 10065
P:212.750.2905 F:212.888.0930