DCW
Dermatology Consultants of Westchester, P.L.L.C. • 2 Overhill Road • Scarsdale, New York 10583 • Tel 914-725-1800 • Fax 914-725-1840

Board Certified Dermatologists
Amy E. Newburger, M.D.
Evelyn Placek, M.D.
Debbie M. Palmer, D.O.
Jessica J. Krant, M.D., M.P.H.
Jennifer S. Kitchin, M.D.
Gregory F. Bishop, M.D.
Julie L. Cantatore-Francis, M.D.

General & Cosmetic Dermatology
Pediatric Dermatology
Mohs Micrographic Surgery

PATIENT INFORMATION:

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

Address:_____
Street Address *City* *State* *Zip*

Sex:_____ **SSN#:**_____ **DOB:**_____ **Age:**_____

Main phone#:_____ **Alt.phone #:**_____ **E-mail:**_____

Marital Status:_____ **Occupation:**_____ **Employer:**_____

PARENT OR RESPONSIBLE PARTY (if different from patient):

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

Address:_____
Street Address *City* *State* *Zip*

Home phone#:_____ **Work Phone#:**_____ **Cell phone#:**_____

Sex:_____ **DOB:**_____ **SS#:**_____ **Relation to patient:**_____

INSURANCE INFORMATION (please present insurance card and photo ID at time of check-in):

Primary Ins:_____
Name of Insured:_____
Insurance ID#:_____
Group#:_____
DOB of Insured:_____
Relation to patient:_____

Secondary Ins:_____
Name of Insured:_____
Insurance ID#:_____
Group#:_____
DOB of Insured:_____
Relation to patient:_____

Other family members that are patients:_____

Primary Care Physician:_____ **Referred by:**_____

Pharmacy of Choice:_____ **Phone#:**_____

In case of emergency, please notify:_____ **Phone#:**_____

CONTACT INFORMATION:

May we leave a message about your appointment.....?
On your answering machine □ **Yes** □ **No** **With another person** □ **Yes** □ **No**

May we leave a message concerning your test results.....?
On your answering machine □**Yes** □**No** **With another person** □**Yes** □**No** **On cell phone** □**Yes** □**No**

Who is authorized to receive this information?(name and relationship):_____

_____

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Patient or Responsible Party Signature:_____ **Date:**_____