Robert E. Pelc, Ph.D., A.B.P.P., P.C.

PATIENT INFORMATION

Today's Date:	Primary Care Physician:	Phone #:

PATIENT INFORMATION

Last Name	**First Name**	**Middle Initial**

Is this your legal name? ☐ Yes ☐ No	Email Address:	Birth date	Age	Sex: ☐ M ☐ F

Address:	City:	State:	Zip Code:

Social Security #:	**Home Phone #:**	**Cell phone #:**
Occupation:	Employer:	Employer phone no.:
Relationship to Guarantor:	Referred By:	

INSURANCE INFORMATION

(Please provide your insurance card)

Person responsible for bill-Guarantor's Full Name:	Birth date:	Address (if different):	Home phone no.:
Occupation:	Employer:	Employer address:	Employer phone no.:

PRIMARY: Name of Insurance Co:

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber/guarantor:

SECONDARY: Name of Insurance Co:	Subscriber's name:	Group no.:	Policy no.:

IN CASE OF EMERGENCY

Emergency Contact:	Relationship to patient:	Home/Cell phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I request and authorize that payment of authorized benefits be made on my behalf. I understand that I am financially responsible for any balance. I also authorize Robert E. Pelc, Ph.D., A.B.P.P., P.C. or insurance company to release any information required to process my insurance claims for current and future services. I assign the benefits payable for services to the provider, Dr. Pelc.

Print Name _____ Sign Name _____