Philip A. Gelacek, M.D. & Associates, PC

PLEASE PRINT

Patient Name _____ Marital Status: M S W D
First MI Last

Street Address_____City_____State____Zip_____

Phone (_____)_____Work (_____)_____Cell (_____)_____

Alternate Phone (_____)_____Name of Alternate Contact _____

Spouse or Parent (if patient is a minor) _____

Spouse phone number other than home phone (_____)_____

Person responsible for payment (if not above) _____

Address of this person (if different from above) _____

Patient Occupation_____Name of employer _____

Address of employer _____Phone Number (_____)_____

DATE OF BIRTH_____SOCIAL SECURITY _____-_____-_____

INSURANCE INFORMATION: Please complete all information

MEDICARE_____

AETNA ID#_____

HIGHMARK PRODUCTS ID#_____

HIGHMARK PRODUCTS GROUP#_____

COPAY AMOUNT $_____

CIRCLE HIGHMARK PLAN YOU HAVE: SECURITY BLUE KEYSTONE BLUE SELECT BLUE
COMMUNITY BLUE KEYSTONE BLUE DIRECT BLUE PPO INDEMNITY

UPMC MEMBER ID#_____EMPLOYER ID_____

HEALTH AMERICA ID#_____GROUP #_____

COPAY AMOUNT $_____

OTHER INSURANCE

NAME_____ADDRESS_____

ID#_____GROUP#_____

Subscribers Name of Insurance_____DOB_____

SS# of subscriber _____-_____-_____Relationship to Patient: self spouse dependent

Address of Subscriber_____

I have reviewed the following treatment plan.
I authorize the release of any information relating to this claim.

_____
Signature

I hereby authorize payment of medical benefits to Philip A. Gelacek, MD for services.

_____
Signature