Phone: 610-868-0104 Fax: 610-868-0204

Robert J. Echenberg, MD
The Echenberg Institute for Pelvic & Sexual Pain
PATIENT DEMOGRAPHICS

NAME: _____ DOB: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

EMAIL ADDRESS: _____

HOME PHONE: _____ CELL: _____

SOCIAL SECURITY #: _____ MARITAL STATUS: _____

OCCUPATION: _____F/T _____ P/T _____

EMPLOYER NAME: _____ PHONE: _____

ADDRESS: _____

PRIMARY DR: _____ PHONE: _____

REFERRING DR: _____ PHONE: _____

IF PATIENT UNDER 18:

MOTHERS NAME: _____ DAYTIME PHONE: _____

FATHERS NAME: _____ DAYTIME PHONE: _____

ADDRESS (IF DIFFERENT): _____

_____

I, the undersigned, understand The Echenberg Institute for Pelvic & Sexual Pain is a Cash Based practice and does not contract with any insurance companies. I promise to pay for all visits and treatments at the time of service based on the established Fee Schedule provided. I agree that if I have insurance coverage that I remain primarily liable for the total amount due and that I will be responsible for submitting out of network paperwork for possible reimbursment.

SIGNATURE: _____ DATE: _____