ROBERT D. PLAMBECK, M.D., P.C.
Obstetrics & Gynecology

PATIENT INFORMATION

Patient Name (Last, First, MI): _____

Patient Address: _____ **City/State/Zip:** _____

Telephone: (Home) _____ **(Cell)** _____ **(Work)** _____

Email: _____ **Patient's Employer:** _____

Date of Birth _____ **SSN:** _____ **Marital Status: S M D W**

RESPONSIBLE PARTY / GUARANTOR / GUARDIAN / SAME AS ABOVE (circle one)

Name (Last, First, MI): _____

Patient Address: _____ **City/State/Zip:** _____

Telephone: (Home) _____ **(Cell)** _____ **(Work)** _____

Email: _____ **Employer:** _____

Relationship to Patient: _____ **Date of Birth** _____ **SSN:** _____

INSURANCE INFORMATION (Please provide copy of Insurance card)

Primary Company: _____ **ID:** _____ **Group #:** _____

Policyholder: _____ **DOB:** _____ **SSN:**_____

Relationship to Patient: _____ **Employer:** _____

Secondary Company: _____ **ID:** _____ **Group #:** _____

Policyholder: _____ **DOB:** _____ **SSN:**_____

Relationship to Patient: _____ **Employer:** _____

ADDITIONAL INFORMATION

Primary Care Physician: _____ **Phone:** _____

Preferred Pharmacy: _____ **Preferred Hospital:** _____

Referred by: _____

Emergency Contact: _____ **Relationship:** _____ **Phone:** _____

Other Contact: _____ **Relationship:** _____ **Phone:** _____

Other Contact: _____ **Relationship:** _____ **Phone:** _____

My signature below indicates that the information above is accurate and correct to the best of my knowledge and ability.

Patient/Guardian: _____ **Date:** _____