Robin T.K. Zeller, Ph.D. CCC-A/SLP
50 Hazelwood Drive
Jericho, NY 11753
P: (516) 932-7577
F: (516) 681-7804

PATIENT INFORMATION

Last Name: _____ First Name: _____
Address: _____
City: _____ State: _____ Zip: _____ Phone: ( )_____
Date of Birth: _____ Sex: _____ Marital Status: _____
Employer: _____ Work Telephone: _____
Spouse: _____ Work Telephone: _____
Emergency Contact: _____ Telephone: _____
Address: _____

INSURANCE INFORMATION

Primary Insurance: _____ ID#: _____
Name of Insured: _____ Relationship to Patient: _____
Date of Birth: _____
Secondary Insurance: _____ ID#: _____
Name of Insured: _____ Relationship to Patient: _____
Date of Birth: _____

PHYSICIAN INFORMATION

Primary Care Physician: _____ Phone Number: _____
Address: _____

I hereby authorize direct payment of medical/surgical benefits to Robin Zeller, Ph.D. for services rendered by her in person or under her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

I here authorize Robin Zeller, Ph.D. too release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

I certify that the information give by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorize benefits be made on my behalf.

Signature of Patient/Guardian: _____ Date: _____