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INFORMATION FORM

Confidential

Thank you for your interest in the treatment programs offered in the Center for Behavioral Medicine. Please refer to the Welgan Center for Behavioral Medicine website to learn about the various disorders treated at the Center and the treatment options available. Also, learn about the free Treatment Orientation meetings scheduled throughout the year at the Center (see website).

Please complete this confidential information form identifying the condition for which you are interested in receiving treatment. Place a check mark next to the condition. If you are interested in treatment for another condition, please indicate the condition below.

Please **E-mail** the completed form to peterrwelganph.d@cox.net, or **Fax** the form to (949) 509-6576. You may also **mail** your form to the Center at the address above.

NAME _____ Age _____
Print First Middle Last

ADDRESS _____ Date _____

PHONE _____ FAX _____ E-MAIL _____

I AM INTERESTED IN THE TREATMENT PROGRAM FOR: (Check)

- 1) Obesity/Weight management _____
- 2) Irritable Bowel Syndrome (IBS) _____
- 3) Ulcerative Colitis _____
- 4) Crohn's Disease _____
- 5) Gastroesophageal Reflux Disease _____
- 6) Other _____ Indicate disorder _____.