

# Gerhard W. Cibis, M.D., PC

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## Patient Information Sheet

REASON FOR APPT:

Patient Name _____			Patient's SSN _____ - _____ - _____		
_____	_____	_____			
_____	_____	_____			
Address _____		D.O.B. ____/____/____		Age ____ Sex: M or F	
_____	_____	_____			
City _____ State _____ Zip _____			Marital Status: _____		
			____ Single ____ Married ____ Divorced ____ Widowed		
Home Phone ( ) _____ - _____		Cell Phone ( ) _____ - _____			
PCP _____ Ph# ( ) _____		Who referred you to us? _____			
_____		_____			
Emergency Contact _____		Phone ( ) _____ - _____			
_____		_____			
Who is financially responsible for these services? ____ Self ____ Spouse ____ Parent/Guardian ____ Work Comp ____ Other					
If responsible party is someone other than you, please provide their name and ssn in the space provided.					
_____			_____		
Full Name			SSN		
Email address: _____					

### Patient's Employer Information

### Spouse/Responsible Party's Employer Information

Company \_\_\_\_\_

Company \_\_\_\_\_

Occupation \_\_\_\_\_

Occupation \_\_\_\_\_

Work Phone ( ) \_\_\_\_\_ - \_\_\_\_\_ Ext \_\_\_\_\_

Work Phone ( ) \_\_\_\_\_ - \_\_\_\_\_ Ext \_\_\_\_\_

### **Insurance Information**

**\*YOU MUST PROVIDE A COPY OF YOUR MEDICAL INSURANCE CARD\***

Will services be: filed with insurance \_\_\_\_ or self pay \_\_\_\_?

Is there a separate vision plan? Yes/No If yes, vision plan name \_\_\_\_\_

#### **Primary Insurance Coverage**

#### **Secondary Insurance Coverage**

Name of Insurance \_\_\_\_\_

Name of Insurance \_\_\_\_\_

Name of Subscriber \_\_\_\_\_

Name of Subscriber \_\_\_\_\_

SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_

SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_

Insurance ID Number \_\_\_\_\_

Insurance ID Number \_\_\_\_\_

Group Number \_\_\_\_\_

Group Number \_\_\_\_\_

Send Claims to \_\_\_\_\_

Send Claims to \_\_\_\_\_

I hereby authorize Gerhard W. Cibis MD PC to furnish information to insurance carriers concerning my illness and treatments, and assign to physician all payments concerning medical services for myself and dependents. I understand that I am responsible for any amount not covered by my insurance.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date