

Pediatric Patient Information Sheet

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REASON FOR APPT:

Patient Name _____ Last First M.I.	Patient's SSN _____ - _____ - _____
Address _____ Street Apt#	D.O.B. ____/____/____ Age ____ Sex: M or F
City State Zip	Pediatrician _____ Ph# _____ Name
Responsible Party's Name _____	Street Address/City/State/Zip _____
Responsible Party's SSN _____ - _____ - _____	Doctor who referred you to us _____
Relationship to Patient _____	_____

Parent/Guardian Info

Email address: _____

Father's Name _____
Last First M.I.

Mother's Name _____
Last First M.I.

Address _____
Street Apt#

Address _____
Street Apt#

City/State/Zip _____
Home Phone () _____ - _____

City/State/Zip _____
Home Phone () _____ - _____

Cell Phone () _____ - _____

Cell Phone () _____ - _____

D.O.B. ____/____/____ SSN _____ - _____ - _____

D.O.B. ____/____/____ SSN _____ - _____ - _____

Occupation _____

Occupation _____

Employer _____

Employer _____

Work Phone () _____ - _____ Ext. _____

Work Phone () _____ - _____ Ext. _____

Emergency contact (not living with patient) _____ Name	Home Phone () _____ - _____
Relationship to patient _____	Alt. Phone () _____ - _____

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

Name of Insurance _____

Name of Subscriber _____

SSN _____ - _____ - _____

Insurance ID Number _____

Group Number _____

Send Claims to _____

Secondary Insurance Coverage

Name of Insurance _____

Name of Subscriber _____

SSN _____ - _____ - _____

Insurance ID Number _____

Group Number _____

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