Gerhard W. Cibis, M.D., PC

Marcia E. Bray, OD
Kelly E. Glass, OD
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Patient Information Sheet

REASON FOR APPT:

Patient Name_____ **Patient's SSN**_____-_____-_____
Last First M.I.

Address _____ **D.O.B.**____/___/____ **Age**___ **Sex: M or F**
Street Apt#

_____ **Marital Status:**_
City **State** **Zip** __ **Single** __**Married** __**Divorced** __**Widowed**

Home Phone (**)**_____-_____ **Cell Phone (** **)**_____-_____

PCP_____ **Ph# (** **)**_____ **Who referred you to us?**_____
Name Name

Emergency Contact_____ **Phone (** **)** _____-_____
Name

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

Company_____

Occupation_____

Work Phone ( )_____-_____Ext_____

Spouse/Responsible Party's Employer Information

Company_____

Occupation_____

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

Name of Insurance_____

Name of Subscriber_____

SSN_____-_____-_____ **D.O.B**____/____/_____

Insurance ID Number_____

Group Number_____

Send Claims to_____

Secondary Insurance Coverage

Name of Insurance_____

Name of Subscriber_____

SSN_____-_____-_____ **D.O.B**____/____/_____

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**