Pediatric Patient Information Sheet
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Pediatric Ophthalmology and Strabismus

REASON FOR APPT:

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

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

_____ **Pediatrician**_____ **Ph#**_____
City State Zip 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_____ **Mother's Name**_____
Last First M.I. Last First M.I

Address_____ **Address**_____
Street Apt# Street Apt#

_____ _____
City/State/Zip City/State/Zip

Home Phone (**)**_____-_____ **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)_____ **Home Phone (** **)**_____-_____
Name

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**