Gerhard W. Cibis, M.D., PC

520 E 63rd ST Kansas City MO 64110

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 ___?

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**