Pediatric Patient Information Sheet
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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_____
Last First M.I.

Address_____
Street Apt#

_____
City/State/Zip

Home Phone (**)**_____-_____

Cell Phone (**)** _____-_____

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

Occupation_____

Employer_____

Work Phone (**)**_____- _____ **Ext.**_____

Mother's Name_____
Last First M.I

Address_____
Street Apt#

_____
City/State/Zip

Home Phone (**)**_____-_____

Cell Phone (**)**_____-_____

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

Occupation_____

Employer_____

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 ___?

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**