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IN OFFICE USE
ONLY:
Date of Service:

PL IND JOCO

AVVDA PATIENT SCREENING INFO SHEET

Patient's Name: _____

DOB: _____ *Age* _____ *M or F*

Address: _____

Home Phone: _____

Pediatrician: _____

Please list name(s) of immediate family members that are seen by us: _____

****Please provide a copy of the patient's insurance card****

Name of Insurance Co: _____

Subscriber's Name: _____

Subscriber's DOB: _____

Employer: _____

ID/Group #: _____ / _____

SSN: _____

I understand that there is a fee for the screening service, and I will not be billed for any unpaid services by my insurance company. Dr. Cibis may deem it necessary to obtain a video image of my child's eyes for unidentifiable research and publication purposes.

Parent/Guardian Signature _____ **Date** _____