

PATIENT INFORMATION SHEET

TIMOTHY W GIBSON, M.D.,INC

17742 BEACH BLVD STE 245

HUNTINGTON BCH, CA 92647

(714) 848-1911

PATIENT INFORMATION			ACCOUNT NO	INSURANCE COMPANY INFORMATION		
PATIENT NAME			1. PRIMARY INSURANCE COMPANY NAME			
Address			Address			
Address (cont'd)			City	State	Zip	
City	State	Zip	Policy Holders Date of Birth	Relationship to Patient: CIRCLE ONE Self Husband Wife Father Mother Other		
Home Phone	Work	Ext	Cell	ID Number of Policy Holder REQUIRED		Group Number
Sex Male Female	Birth Date		Age	2. SECONDARY INSURANCE COMPANY NAME		
SSN		Driver's License		Address		
Marital Status Single Married Widowed Divorced Separated			City	State	Zip	
INJURY INFORMATION (MUST BE COMPLETED)			Policy Holders Birth Date		Relationship to Patient	
LIST BODY PART TO BE EXAMINED: RIGHT LEFT			ID Number of Policy Holder REQUIRED		Group Number	
DATE of INJURY or ACCIDENT: (REQUIRED by your Insurance) mm dd yy			SPOUSE INFORMATION			
WERE YOU INJURED ON THE JOB? YES NO			Full Name			
WAS THIS AN AUTOMOBILE ACCIDENT? YES NO			Birth Date			
RESPONSIBLE PARTY (IF DIFFERENT FROM ABOVE)			SSN			
Name			Employer			
Address			NEAREST RELATIVE			
City	State	Zip		Name		
Relationship to Patient (Self,Spouse,Parent,Other)			Address			
Phone	SSN		City	State	Zip	
PATIENTS EMPLOYER INFORMATION (If the patient is a minor list the insureds employer)			Phone		Relationship to Patient	
Company Name			Referred by 1. Doctor		Phone# ()	
Address			2. Previous Patient of Doctor you are seeing today: Yes No			
City	State	Zip		LIST ANY ALLERGIES		
Occupation		Self-Employed		1. 2.		
Work Phone			3. 4.			

Insurance Authorization and Assignment:

I hereby authorize physician listed above to furnish information to carriers concerning my illness, injury and treatment.
I hereby assign to the physician all payments for medical services rendered to myself or my dependents.
I understand that I am responsible for any amount not covered by my insurance.

SIGNATURE	DATE
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