WELCOME TO OUR OFFICE!

Today's Date

PATIENT INFORMATION

Name: _____ (First) _____ (Last) _____ (Middle)

S.S. # (Last 4 Digits Only): _____ Gender: ____ Male ____ Female Home Phone: _____

Cell Phone: _____ Cell Phone Carrier: _____ May we confirm appointments via text? ___ Yes ___ No

Home Address: _____ (Street) _____ (City) _____ (State) _____ (ZIP)

E-mail Address: _____

Employer (or School): _____ Occupation (or Grade): _____ Work Phone: _____

Spouse's (or Parent's) Name: _____ Spouse's (or Parent's) Work Phone: _____

Date of Birth: _____ Marital Status: ___Single ____Married ____Divorced ____Widowed Student Status: ____FT ___ PT ___N/A

HEALTH HISTORY

	No	Self	Family	Relationship
Glaucoma	☐	☐	☐	
Cataracts	☐	☐	☐	
Macular Degeneration	☐	☐	☐	
Blindness	☐	☐	☐	
Crossed Eye	☐	☐	☐	
Lazy Eye	☐	☐	☐	
Diabetes	☐	☐	☐	
High Blood Pressure	☐	☐	☐	
Other Eye Disease	☐	☐	☐	

Family Physician: _____ Phone: _____

Current Medications (including eye drops):

_____

_____

☐ Check here if current medication list is continued on back of sheet.

Known Allergies:

_____

	No	Yes	Explain
Cardiovascular (Heart, Stroke, Cholesterol)	☐	☐	
Ear, Nose, Throat (Hearing, Sinus Infection)	☐	☐	
Respiratory (Asthma, TB, COPD, Sarcoid)	☐	☐	
Gastrointestinal (Diverticulitis, Crohn's)	☐	☐	
Genitourinary (Dialysis, STD, Cancer)	☐	☐	
Muscoloskeletal (Arthritis, MS)	☐	☐	
Skin (Cancer, Rosacea)	☐	☐	
Neurological (Stroke, TIA, Bell's Palsy)	☐	☐	
Psychitatric (Dementia, Depression)	☐	☐	
Endocrine (Thyroid)	☐	☐	
Hematologic (Anemia, Leukemia)	☐	☐	
Immune (HIV, Lupus)	☐	☐	
Migraines/Frequent Headaches	☐	☐	
Sleep Apnea	☐	☐	
Currently Pregnant/Recent Childbirth	☐	☐	
Dry Eyes	☐	☐	
Other _____	☐	☐	

PAYMENT INFORMATION

Medicare Number: _____

Blue Cross Blue Shield Number: _____

Medicaid Number (XIX): _____

Vision Plan Information

Name of Vision Plan: _____

Identification Number: _____

Name of Insured: _____

Insured's Birthdate: _____

Other Insurance Information

Name of Insurance: _____

Identification Number: _____

Name of Insured: _____

Insured's Birthdate: _____

Insured's Address (if different than patient's address):

_____

Who is financially responsible for this bill?

_____

I hereby authorize the release of any medical or other information necessary to process any claims on my behalf and to request benefits to either myself or to Sigma. I understand and agree that, regardless of my status, I am ultimately responsible for the balance on my account for any professional services rendered. I certify that the information I have provided on this form is true and correct to the best of my knowledge. I will notify Sigma of any changes in my health status or changes to any of the above information.

_____

Signature of Patient (or Guardian, if Patient is a minor) Date

Updated (Initial & Date): _____ _____ _____ _____ _____