FISHMAN & SHERIDAN eyeCare SPECIALISTS

Patient Information Sheet

Patient's Name: _____ Date: _____

Home Phone: (_____)_____ Cell: (_____)_____ Other: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____/_____/_____ Age: _____ Social Security Number: _____-____-_____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow(er)

Spouse's Name: _____

Primary Health Insurance: _____
(please allow us to copy ID cards for our records)

Secondary Health Insurance: _____

Name of Primary Insured, *if other than patient*: _____ DOB: ____/____/_____

Employer: _____ Phone: (_____)_____

Family Physician: _____ Phone: (_____)_____

Name of Local Pharmacy: _____ Phone: (_____)_____

Mail Order Pharmacy: _____

How did you hear about us?

- ☐ Family or Friend referral (Name): _____
- ☐ Physician referral (Name): _____
- ☐ Internet / Website
- ☐ Other: _____

Preferred method of contact:

☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Text Message ☐ E-mail

E-mail address: _____@_____

Emergency Contact Person

Name: _____ Relationship: _____

Phone: (_____)_____

Continued next page...

Patient's Name: _____

Medical Information

Do you have, or have you had, any of the following: (check all that apply)

- ☐ Asthma
- ☐ Cataracts
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Macular Degeneration
- ☐ Other: _____

Do any of your relatives have any of the above diseases? If so, which disease(s), and what is their relationship to you? _____

_____

Check any of the following that apply:

- ☐ I am now, or it is possible that I am pregnant
- ☐ Wear glasses or contact lenses
  Date of last eye exam: _____ By Whom: _____
- ☐ Use eye drops
  Specify: _____
- ☐ Allergies
  Specify: _____

List all medications you are currently taking: (attach separate sheet if necessary)

_____ _____

_____ _____

_____ _____

_____ _____

By your signature below, you authorize us to bill your insurance company (if applicable) on your behalf for any covered services and agree to the release of medical information about you to your insurance company as necessary to process your claim.

Your signature below also confirms your agreement to pay for any non-covered and/or out-of-pocket responsibilities such as co-pays and deductibles, at the time service is rendered.

PATIENT IS RESPONSIBLE TO VERIFY PROVIDER PARTICIPATION IN INSURANCE PLAN AND TO OBTAIN ANY REQUIRED INSURANCE AUTHORIZATIONS PRIOR TO VISIT.

_____ Date: _____

Patient's Signature