Victor Bisignano, OD & Associates

Welcome to Our Office

Today's Date___________________________

Name____SS#____

Spouse/Parent/Partner____

Address____City, Zip_____________________________________

Telephone (H)___________________________ (W)____

Date of birth_________________________ Age______________E-Mail_______________________________________

Occupation_________________________________Employer/School____

Date of last eye exam?_____________________Where?____

Primary physician, address & phone #:____

Whom may we thank for referring you to us?
____

Interests : Hobbies, Sports, Leisure Activities____

YOUR GENERAL HEALTH AND EYE HISTORY:

___Diabetes	___High blood pressure	___Lazy eye	___See floaters/spots
___Allergies	___Stroke	___Glaucoma	___Currently pregnant
___Frequent headaches	___Cancer	___Eye surgery	___Thyroid condition
___Tuberculosis	___Skin conditions	___Eye/infections	___Lyme disease
___Asthma	___HIV	___Retinal disorders	___Arthritis

Present medications taken____

List any allergies or sensitivities to medications____

Do you presently wear eyeglasses? Y/N How old are they?____

Do you wear contact lenses? Y/N Brand:____

How often are your contact lenses replaced?____

FAMILY GENERAL HEALTH AND EYE HISTORY (blood relatives)

Diabetes Y/N Relation______________ Macular Degeneration Y/N Relation_______________

Glaucoma Y/N Relation_____________ Eye disease Y/N Relation________________________

********CONTACT LENS WEARERS********

If you wear contact lenses on a regular basis, we are obligated by the standards and ethics of our profession to perform a contact lens examination. Since extra time and expertise are needed, an additional fee is charged. Rarely is this fee covered by any insurance. If you would like to discuss this in further detail, please let us know before your exam. ***Contact lens fitting fees are not refundable.***

Minors: Parent or guardian authorizes the prescription, application and use of contact lenses for the above minor.

INSURANCE INFORMATION

Insurance, Name of plan____

Your group and ID#'s____

Policy Holder____DOB________________________________

Relationship to the policy holder____

Sorry we do not bill. Payment is expected time of service. ***Cash_____ Ck_____ Ins_____ Visa/MC _____***

SIGNATURE ON FILE STATEMENT

I, the undersigned, authorize the use of this form on all my insurance submissions and the release of all information to my insurance company. I authorize payment directly to Dr. Victor Bisignano and Associates, although I understand that I am responsible for my bill regardless of insurance coverage.

Signature of patient or guardian if minor____Date____________