SCOTT C SIGLER, MD

PATIENT REGISTRATION

PATIENT

Last Name:____________________ First:____________________ MI:________

Home Address:____________________ City:____________ State:________ Zip:________

Phone Home:____________________ Work:____________ Mobile:____________

Preferred Method of Contact (circle one): Home Work Mobile Email

Email:____________________ Language:____________ Race:________

Sex (circle): F M Age:________ Date of Birth:____________ Place of Birth:____________

Marital Status:(circle one): Child S M W D Social Security #:____________

Spouse:____________________ Phone:____________________

If Minor, Responsible Party Name, Address & Phone:____________________

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Patient Employer:____________________ How Long?____________

Address:____________________ City:____________ State:________ Zip:________

PRIMARY INSURED

Last Name:____________________ First:____________________ MI:________

Address:____________________ City:____________ State:________ Zip:________

Social Security #:____________________ Date of Birth:____________________

Place of Employment:____________________ Work#:____________________

Relationship to Patient:____________________ Home#:____________________

Name of Insurance:____________________ Group#:____________________

ID#:____________________ Are you covered by Medicare? (circle) Y N

Secondary Insurance: ____________________ Group#:____________________

ID#:____________________ Relationship to patient:____________________

Policy Holder Name:____________________ Policy Holder Date of Birth:____________

ALTERNATIVE CONTACT INFORMATION

Name(other than spouse):____________________ Relationship to patient:________

Home#:____________________ Work#:____________________

SCOTT C SIGLER, MD

PRIMARY CARE PHYSICIAN

Name:______________________________ Phone:______________________

Address:____________________________ City:______________ State:__________

REFERRING PHYSICAN

Name:______________________________ Phone:______________________

Address:____________________________ City:______________ State:__________

PREFERRED PHARMACY

Name:______________________________ Phone:______________________

Address:____________________________ City:______________ State:__________

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of medical benefits to Dr. Sigler for services rendered. I understand I am financially responsible for any balance not covered by my insurance.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Dr. Sigler to release any medical or incidental information that may be necessary for either medical care or processing applications for financial benefit.

MEDICARE

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

FINANCIAL RESPONSIBILITY

I understand if my account becomes delinquent after 90 days, I will be subject to pay all costs of collection, including but not limited to a reasonable attorney fee unless financial arrangements have been made and agreed to by myself and the office of Dr. Scott Sigler. ____________(initial)

PATIENT NAME (Please print) ______________________________ **DATE**__________

PARENT/GUARDIAN (if patient is under 18)______________________________

SIGNATURE______________________________ **DATE**__________

SCOTT C SIGLER, MD

CONSENT TO CONTACT ACCOUNT HOLDER

I agree, in order for you to service my account or to collect any amounts I may owe, you may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers which could result in charges to me. You may also contact me by sending text messages or Emails, using any Email address I provide to you. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device as applicable.

I/We have read this disclosure and agree that the I/we may be contacted as described above.

____

PATIENT/PARENT SIGNATURE **DATE**

PHOTOGRAPHS

I ______________________________ give my permission for photographs to be taken of me. The photographs will be used for medical record purposes so that the eye condition may be studied and if surgery is required, the pre-operative and post-operative appearances may be compared. Also, photographs are needed to submit to the insurance company for many procedures in order to determine whether the surgery will be approved or denied. I understand that my name will not be used and my privacy will be insured.

____

PATIENT/PARENT SIGNATURE **DATE**

SCOTT C SIGLER, MD

HIPPA CONSENT FORM

This consent form must be completed and signed prior to receiving medical treatment from our office. Please return this form to the receptionist upon completion.

I understand that as a part of my medical care, this office originates and maintains medical records describing my health history, symptoms, examinations and test results, diagnoses, treatment, and any plans for future care or treatment. I further understand that this information serves as:

- A basis for planning my care and treatment
- A means for communication among the health professionals who contribute to my care
- A source of information for applying my diagnosis and treatment information to my bill
- A means for a third-party payer to verify that services were billed as actually provided
- As a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professional

By Oklahoma law we are required to notify you **that the information authorized for release may include records which may indicate the presence of communicable or venereal disease which may include, but are not limited to, disease such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).**

Other than myself, this office has permission to use and disclose information regarding my appointment dates/times and my protected health information to the following specific person(s):

____

Name of Person(s) **Relationship to Patient**

This agreement to release future information shall remain in force until such time as I revoke in writing:

I understand and have been provided a **PATIENT PRIVACY NOTICE** that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that this office reserves the right to change the notice and practices, but that prior to implementation, a copy of any revised notice will be provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that my doctor is not required to agree to the restrictions requested. I understand that I must revoke this consent in writing: except to the extent the organization has already taken action.

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SIGNATURE OF PATIENT OR LEGAL GUARDIAN

____

PRINTED NAME AND RELATIONSHIP TO PATIENT **DATE**

History and Intake Form

REASON FOR VISIT TODAY________________________

Past Medical History: (please circle all that apply)

NONE
Anxiety
Arthritis
Artificial joints
Asthma
Atrial fibrillation
BPH
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
OTHER

Hearing Loss
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Pacemaker
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Valve Replacement

Past Surgical History: (please circle all that apply)

NONE
Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
PTCA

Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement within last 2 years
Kidney Biopsy
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst

(Surgical History Continued):

Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP
Skin Biopsy
Basal Cell Cancer Surgery
Squamous Cell Carcinoma Surgery
Melanoma Surgery
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer

OTHER____

Ocular History: (please circle all that apply)

NONE
Allergic conjunctivitis
Blepharitis
Cataract (Left eye, Right eye)
Corneal dystrophy (Left eye, Right eye)
Diabetic retinopathy, background (Left eye, Right eye)
Dry eyes
Glaucoma (Left eye, Right eye)
Macular degeneration (Left eye, Right eye)
Macular ERM (Left eye, Right eye)
Narrow angles (Left eye, Right eye)
Ocular hypertension (Left eye, Right eye)
Ophthalmic Migraine
Pseudoexfoliation
Retinal tear (Left eye, Right eye)
Strabismus
PVD (Left eye, Right eye)
Vitrous floaters (Left eye, Right eye)

OTHER____

Ocular Surgery: (please circle all that apply)

NONE
Blepharoplasty (Left eye, Right eye)
Cataract surgery (Left eye, Right eye)
Corneal transplant (Left eye, Right eye)
DSAEK (Left eye, Right eye)
Eye Muscle Surgery
Intravitreal injections (Left eye, Right eye)
LASIK (Left eye, Right eye)
LPI (Left eye, Right eye)
LTP (Left eye, Right eye)
PRK (Left eye, Right eye)
Ptosis repair (Left eye, Right eye)
Punctal plugs (Left eye, Right eye)
Strabismus surgery
Retinal laser (Left eye, Right eye)
Trabeculectomy (Left eye, Right eye)
Tube shunt (Left eye, Right eye)
Yag capsulotomy (Left eye, Right eye)

OTHER________________________
____

Family History: (circle all that apply)
Please List All Family Members

NONE
Blindness____
Cancer____
Cataracts____
CVA____
Diabetes____
Glaucoma____
Heart disease____
Macular degeneration_____________________________________
Migraine____
Retinal detachment_______________________________________
Strabismus____
OTHER

____

MEDICATIONS: (Please **PRINT** all current medications, prescription eye drops, including all over the counter meds and supplements)

NAME	STRENGTH	DOSE	FREQUENCY

NONE

Allergies: (Please enter ALL allergies)

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____

____

NONE

Social History: (Please circle all that apply)

Cigarette Smoking:
- Never smoked
- Quit: former smoker
- Smokes less than daily
- Smokes daily

Drug Use:
- IV Drug Use

Alcohol Use:
- Alcohol: none
- Alcohol: less than 1 drink a day
- Alcohol: 1-2 drinks a day
- Alcohol: 3 or more drinks a day

Other____

NONE