Greenbriar Vision Center Welcomes You

Please Print Clearly

Patient Information

Name (Mr/Mrs/Ms):____ Date:___________________

Address: ____

City:____________________________ State:____________________ Zip:______________________

Home #:____________________Work #:________________________ Cell#:____________________

Email:____

Sex:______________________ Birth date: ______________________ Age: ____________________

Parent/Guardian's name (if patient is a minor):____

Patient/Parent's Occupation:____

How did you hear about our office?____

Person to contact in case of emergency?____

Insurance Information

Eye Insurance Name:____

Name of insured person:______________________________ Birth date:______________________

Relationship to patient:_______________________________ Policy/ID #:______________________

Additional Insurance (Circle one: Yes No)

Insurance Name:____

Name of insured person:______________________________ Birth date:______________________

Relationship to patient:_______________________________ Policy/ID #:______________________

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I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. Should my account become delinquent, I agree to pay the outstanding balance owed.

Checks which are returned for insufficient funds will result in a $25 charge to the patient account.

Signature of patient or parent/guardian:____

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Medical History Record

Patient Name:____

Date of last eye exam:____________________ **Name of previous eye doctor:**____________________

Have you ever worn glasses? (Circle one)

Yes **No** **How are they used?** **Distance** **Near** **Constantly**

Have you ever worn contacts? (Circle one)

Yes **No** **How long?**__________ **Type?** **Soft** **Gas permeable** **Hard**

Ocular Health (please check all that apply)

Family	Self	
		Blindness
		Cataracts
		"Crossed eyes"
		"Lazy eye"
		Floaters
		Glaucoma
		Amblyopia
		Retinal Disorders
		Eye injuries (scratches, blow to the eye)

General Health (please check all that apply)

Family	Self	
		Pregnant
		High blood pressure
		Diabetes
		Allergies
		Cancer
		Arthritis
		Respiratory problems
		Circulatory problems
		Multiple sclerosis
		Other

If you are presently taking any medications, hormones, or birth control pills, please list them here:____

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Are you allergic to any medication or eye drops? Please list ______________________________

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