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?_____

Hobbies _____

Insurance Information

Vision Insurance:_____

Name of insured person:_____ **Birth date:**_____

Employer:_____

Relationship to patient:_____ **Policy/SSN #:**_____

Additional Insurance (Circle one: Yes No)

Insurance Name:_____

Name of insured person:_____ **Birth date:**_____

Relationship to patient:_____ **Policy/ID #:**_____

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.

Signature of patient or parent/guardian:_____

In compliance with the new federal guidelines for electronic medical records, patients are required to provide their full medical history.

Date of last eye exam_____ **Doctor/Facility Name**_____

Have you ever worn glasses? (Circle One) Yes No

How are they used? (Circle all that apply) Distance ☐ Near ☐ Full-time ☐ As needed ☐ Computer ☐

How many hours per day do you use the computer/electronics? _____

Have you ever worn contact lenses? (Circle One) Yes No **Do you currently wear contacts?** _____

How long have you worn contacts? _____ **Brand** _____

Type of contact lenses worn/currently wearing? Daily ☐ Two-week ☐ Monthly ☐ Gas ☐ Multifocal ☐

How often do you wear them? _____ **How many hours in the day?** _____ **Solution** _____

Ocular History (please check all that apply)

Family/Who?	Self	
☐	☐	**Blindness**
☐	☐	**Cataracts**
☐	☐	**Crossed eyes, lazy eye, eye turn**
☐	☐	**Floaters/Sudden flashes of light**
☐	☐	**Glaucoma**
☐	☐	**Amblyopia**
☐	☐	**Retinal Disorders**
☐	☐	**Eye injuries (scratches, blow to the eye, etc.)**
☐	☐	**Lasik/PRK – if so, when:**
☐	☐	**Macular degeneration**
☐	☐	**Sudden loss of vision**
☐	☐	**Eye Surgery (please explain)**

General Health (please check all that apply)

Family/Who?	Self	
	☐	**Are you currently pregnant?**
☐	☐	**High blood pressure, heart disease**
☐	☐	**Diabetes Last A1C**
☐	☐	**Cancer What type:**
☐	☐	**Arthritis**
☐	☐	**Multiple sclerosis**
☐	☐	**Tobacco Use-never smoked, in past or currently (if so, how often)**
	☐	**Alcohol Use – if so, how often**
	☐	**Narcotic Use – if so, type (recreational, medically necessary)**
	☐	**Surgical History**

Please list any medication(s)/vitamins and the condition(s) you are taking it for:

Medication	Treatment for:

Medical History

	Yes/No	Description (please be specific)
Allergies (seasonal, medications, other)		
Cardiovascular (hypertension, heart disease, pacemaker, etc.)		
Constitutional (general ailments: fainting, appetite, anemia, fever, chills, weight loss, etc.)		
Endocrine (diabetes, cholesterol, thyroid, gout, kidney disease, Crohn's, etc.)		
Gastrointestinal (GERD, constipation, diarrhea, etc.)		
Genitourinary (bladder disorders, pregnancy disorders, ovarian disorders, prostate disorders, etc.)		
Head, Ear, Nose, Throat Disorder (hearing loss, sinus problem, etc.)		
Hematologic/lymphatic/Immunologic		
Skin (rashes, cancer, etc.)		
Musculosketal (joint pain, arthritis, osteoporosis, etc.)		
Neurological (seizures, migraines, stroke, headaches, etc.)		
Psychiatric (anxiety, depression, insomnia, etc.)		
Respiratory (asthma, COPD, cough, shortness of breath, etc.)		

Greenbriar Vision Center Office Policy

Insurance

Insurance information must be collected on the date of your exam. You are financially responsible for any charges and balances not covered by your insurance.

Medical visits are not covered by vision plans. If you are being treated for a medical related eye condition, our office may be able to bill to your medical insurance company for you. However, submission to your insurance is not guaranteed coverage, as some or all services may not be a covered benefit with your plan. You are ultimately responsible for all copayments, non-covered charges, and deductibles as stated by your insurance company.

Contacts

The contact lens evaluation fee includes necessary follow up visits for 30 days.

Opened or marked contact lens boxes cannot be returned for a refund.

Payment

Payment is due at the time of service. We accept cash, credit cards, and checks.

Any returned checks are subject to a $35 fee.

If your account is over 60 days late, you will accrue a $10 late fee each month that it is late.

If ordering glasses or contacts, at least half payment is due at the time of order. The remaining balance must be paid in full at the time of dispense.

Eyeglass returns must be made within 30 days of the purchase date, are subject to a 30% restocking fee, and approval from the practice manager.

Appointments

The allotted time slot scheduled for your appointment is for you. **As a courtesy to the doctor and other patients, if you are 15 minutes late to your appointment, you may be asked to reschedule and you will be charged a missed appointment fee.**

Any missed appointments or cancellations not given 24 hours notice will be subject to a cancellation fee of $25 per missed appointment. This balance must be paid before you are allowed to schedule another appointment.

_____

Print Name

_____ _____

Signature Date