Greenbriar Vision Center Welcomes You

Please Print Clearly

First Name _____ ***Last Name*** _____ ***Today's Date*** _____

Address _____

City _____ ***State*** _____ ***Zip Code*** _____

Home # _____ ***Work #*** _____ ***Cell #*** _____

Email _____

Sex: _____ ***Birth date:*** _____ ***Age:*** _____

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

Patient/Parent's Occupation: _____

Person to contact in case of an emergency? _____

Hobbies _____

Vision Insurance Information

Vision Insurance _____

Name of insured person _____ ***Date of Birth*** _____

Employer: _____

I.D #/Last four of SSN #: _____ ***Relationship to patient:*** _____

Medical Insurance

Insurance Name: _____

Insurance Address _____

City _____ ***State*** _____ ***Zip Code*** _____

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

Policy/ID #: _____ ***Group #*** _____

Relationship to patient _____ ***Phone #*** _____

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

Name:_____ **DOB**:_____ **Date of Last Exam** _____

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

How are they used? (Circle all that apply)

Distance Vision Only Reading Computer Progressives Bifocal/Trifocal

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? _____

Type of contact lenses worn/currently wearing? (Circle One)

Daily Disposable Two-week Monthly Gas Permeable

Contact Lens Brand _____ ***Contact Lens Solution*** _____

How often do you wear them? (Circle One) Every day Occasional Wear

How many hours in the day do you wear your contacts lenses? _____

Are you happy with the contacts that you're currently wearing? _____ ***If not, what would you like to change about them?*** _____

Ocular History (please check all that apply)

	Self	**Family/Who?**
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	☐	☐

Ocular History continued (please check all that apply)

Do you have problems with:	YES	NO	SEVERITY
Dry Eye **(Gritty, Scratchiness, etc)**			
Eye itching, burning, soreness, or watering			

Eye Surgical History (please be specific)

Please list any eye drops including artificial tears and allergy drops that you are using:

Medication	Treatment for:

General Health

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

Medication	Treatment for:

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

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.)		
Musculoskeletal (joint pain, arthritis, osteoporosis, etc.)		
Neurological (seizures, migraines, stroke, headaches, etc.)		
Psychiatric (anxiety, depression, insomnia, etc.)		
Respiratory (asthma, COPD, cough, shortness of breath, etc.)		