

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 #:

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	
<input type="checkbox"/>	<input type="checkbox"/>	Blindness
<input type="checkbox"/>	<input type="checkbox"/>	Cataracts
<input type="checkbox"/>	<input type="checkbox"/>	"Crossed eyes"
<input type="checkbox"/>	<input type="checkbox"/>	"Lazy eye"
<input type="checkbox"/>	<input type="checkbox"/>	Floaters
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma
<input type="checkbox"/>	<input type="checkbox"/>	Amblyopia
<input type="checkbox"/>	<input type="checkbox"/>	Retinal Disorders
<input type="checkbox"/>	<input type="checkbox"/>	Eye injuries (scratches, blow to the eye)

General Health (please check all that apply)

Family	Self	
<input type="checkbox"/>	<input type="checkbox"/>	Pregnant
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Respiratory problems
<input type="checkbox"/>	<input type="checkbox"/>	Circulatory problems
<input type="checkbox"/>	<input type="checkbox"/>	Multiple sclerosis
<input type="checkbox"/>	<input type="checkbox"/>	Other

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

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