GRENE VISION GROUP

TOTAL EYE CARE FOR THE ENTIRE FAMILY

Welcome to our office. Please complete this form to the best of your knowledge.

GENERAL INFORMATION: Today's Date ___ / ___ / _____

Patient Name: _____
First Middle Last

How do you wish to be addressed? (e.g. - Mr., 1st Name, Nickname) _____

Social Security Number: ____ - ____ - ____ Date of Birth: ___ / ___ / _____ Gender: ❑ M ❑ F

Home Address: _____
Street City State Zip

Race: _____ Language: _____

Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Unknown/Not Reported

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Home Phone: (___) ____ - _____ Cell Phone: (___) ____ - _____ Work Phone: (___) ____ - _____

E-mail address: _____

Emergency Contact: _____ Relationship: _____ Phone: (___) ____ - _____

Your Occupation: _____ Employer: _____ Work #: (___) ____ - _____

Primary Care Physician: _____

BILLING INFORMATION (if different from patient):

Name of Person Financially Responsible for Account: _____

Relationship to Patient: _____ SSN: ____ - ____ - ____ DOB: ___ /___ / _____

Home Phone: (___) ____ - _____ Cell Phone: (___) ____ - _____ Work Phone: (___) ____ - _____

Address: _____
Street City State Zip

INSURANCE:

Primary Insurance: _____ Policy Number: _____ ID#: _____

(if policy holder different than billing info, need SS ____ - ____ - _____ & DOB: ___ / ___ / ____)

Secondary Insurance: _____ Policy Number: _____ ID#: _____

(if policy holder different than billing info, need SS ____ - ____ - _____ & DOB: ___ / ___ / ____)

I do hereby authorize the release of any medical information to process all claims, and request payment of any medical benefit to be paid to Grene Vision Group.

I have received the consent form, received brochure entitled "Notice of Privacy Policies and Practices" and give my permission to GRENE VISION GROUP to use and disclose my health information in accordance with the consent and the notice provided.

X _____ _____ _____

Signature of Patient or Patient Representative | Date | Relationship of Patient Representative to Patient

MEDICAL HISTORY QUESTIONNAIRE

Patient Name: _____ DOB: _____ Today's Date: _____

Medical Doctor: _____ Optometrist (Eye Glasses Doctor): _____

MEDICAL HISTORY (Your personal)

SYSTEMIC	Circle	Explanation
Sjogren's disease	yes no	
High blood pressure	yes no	
Heart valve disease	yes no	
Pacemaker	yes no	
Coronary artery disease	yes no	
Emphysema / asthma	yes no	
Crohn's disease	yes no	
Inflammatory bowel disease	yes no	
Rheumatoid arthritis	yes no	
Headaches	yes no	
Sleep Apnea	yes no	
Do you use a c-pap machine	yes no	

SYSTEMIC	Circle	Explanation
Irregular heart beat	yes no	
Heart attack	**yes no**	**When?**
Stroke	**yes no**	**When?**
Multiple sclerosis	yes no	
Leukemia / Lymphoma	yes no	
Hepatitis	**yes no**	
HIV/AIDS	**yes no**	
Lupus	yes no	
Thyroid disease	yes no	
Diabetes	**yes no**	**YRS? ___ Insulin? Y / N**

OCULAR	Circle	Explanation
Corneal disease	yes no	
Crossed / Lazy eyes	yes no	
Double vision	yes no	
Cataracts	yes no	
Glaucoma	yes no	
Retinal detachment / disease	yes no	

OCULAR	Circle	Explanation
Macular degeneration	yes no	
Optic neuritis	yes no	
Eye injury	yes no	
Do you wear glasses?	yes no	
Do you wear contact lenses?	yes no	

LIST OF MEDICAL PROBLEMS

_____ _____

_____ _____

_____ _____

_____ _____

SURGICAL HISTORY - (Excluding EYE surgeries)

Procedure	Date performed	Doctor
1.		
2.		
3.		

EYE SURGICAL HISTORY - (Eye surgeries ONLY)

Procedure	Date performed	Doctor
1.		
2.		
3.		

FAMILY MEDICAL HISTORY (e.g. father, mother, siblings, grandparents, aunts, uncles, etc.)

SYSTEMIC	Circle	Who?
Diabetes	yes no	
Heart disease	yes no	
High blood pressure	yes no	
Stroke	yes no	
Cancer	yes no	
Lupus	yes no	
Rheumatoid arthritis	yes no	
Thyroid disease	yes no	

OCULAR	Circle	Who?
Blindness	yes no	
Corneal disease	yes no	
Corneal transplant	yes no	
Crossed / Lazy eyes	yes no	
Glaucoma	yes no	
Cataracts	yes no	
Retinal detachment	yes no	
Macular degeneration	yes no	

(Please complete other side)

Patient Name: _____

DOB: _____

SOCIAL HISTORY

	Circle
Do you use tobacco?	yes no formerly
Type: _____	Units/day: _____ Years used: _____ Packs Years: _____ Year quit: _____
Smoker Status:	❑ everyday ❑ some days ❑ former smoker ❑ status unknown ❑ never smoker
Passive smoke exposure?	yes no
Do you use alcohol?	yes no formerly
Do you use illegal drugs?	yes no formerly
Do you drink caffeine?	yes no amount per day: _____

ALLERGIES

	Circle	Explanation
Do you have a latex allergy?	yes no	_____
	If yes, what reaction have you had?	_____
Have you been tested for latex allergy?	yes no	_____
Do you have adhesive / tape sensitivity?	yes no	_____
Do you have reactions to Iodine? Skin or Intravenous	yes no	_____
Have you ever been diagnosed with a staph infection, MRSA, VRSA or C-DIF?	yes no	_____

MEDICATION ALLERGIES

Drug	Reaction
1. _____	_____
2. _____	_____
3. _____	_____

MEDICATIONS (name and strength)

Please list all medications you are currently taking.

Prescription Medication Name	Dosage (mg)	How Often
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____

Over the Counter Medication Name	Dosage (mg)	How Often
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____