GREENWOOD Optical

Welcome to **Greenwood Vision**, and **Thank You** for choosing our office! Please take a moment to complete all fields below. All information is strictly confidential.

Patient Name:_____ Date:_____
LAST FIRST M.I.

Please Check One

Address:_____ ☐ Married ☐ Single ☐ Other

_____ Birth Date_____
City State ZIP

☐ **Male** ☐ **Female**

Daytime Contact Number_____ Email_____
This number will reach.....
Self / Parent Or Guardian ☐ CELL ☐ HOME ☐ WORK

Parent / Guardian Name(If Under 18)_____

Full Time Student? YES NO Occupation / School: _____

How Did You Hear About Us? _____

Health Information

Reason for Visit:_____

I am also interested in **contacts** / **glasses** / **both**

Date of last visual exam_____ Do you wear glasses? YES NO Contacts? YES NO

Doctor or office where your last exam was completed_____

Please indicate if your personal and or family history includes the following:

Other unusual health problems? _____

_____

☐ High Blood Pressure ☐ Diabetes
☐ Eye Surgery ☐ Allergies
☐ Eye Diseases ☐ Eye Injuries

Are you currently taking any medications? _____

_____

Payment & Service Disclosures

- I authorize payment of medical benefits to Dr. Marisa Monterola for services rendered.
- I understand I am financially responsible for all charges for services rendered on my behalf or my dependents.
- I have received the Notice of Privacy Practices and have been provided an opportunity to review it.
- I understand that all services are charged to the patient and that this office will courtesy bill my insurance company directly for me. If, however, no payment from insurance is received in 45 days, the balance is due and payable by me. I agree to pay any balance remaining on my account after the insurance has paid. If the physician must utilize a collection agency, an attorney, or a court system, I will be responsibile for all fees.
- I understand there is a $20.00 returned check fee.
- I agree to pay any "co-pay" and any "co-insurance" at the time of service
- I understand that any quote given to this clinic by my insurance company is not a guarantee of payment.
- I have read and understand the information provided above.

Patient Signature_____

Parent/ Guardian Signature _____ **On Behalf Of:**_____

For Office Use Only

Primary Insured:_____ Relationship To Patient:_____

Insurance Provider:_____ Telephone #_____ Representative:_____

Policy #:_____ Group#:_____ Subscriber DOB#:_____

Billing Address: _____

Eligbility Date:_____ Exam:_____ Exam Co-Pay $_____ CL Fit $_____

Frames:_____ S.V._____ BiFocals_____ Tri:_____ Prog_____

Additional Information: _____

_____

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