EST. 1951
GREENWOOD VISION
Seattle Wash.

Welcome to Greenwood Vision and thank you for choosing our practice! Please take a moment to complete ***all*** fields below. All information is strictly confidential.

Date: _____

Patient Name: _____
LAST FIRST

Address: _____ Date of Birth: _____
Street

_____ □ Male □ Female
City State Zip

Daytime Contact Number: _____
Email: _____
Parent / Guardian Name (If Under 18): _____

Hobbies: _____
Occupation: _____
Employer: _____

Insurance Name: _____
Subscriber Name (if other than self): _____
Subscriber Date of Birth: _____
Relationship to Insured: _____
Family Doctor: _____

Reason for Visit: _____

Approximate Date of Last Eye Exam: _____

Doctor or Office where your last exam was completed:
_____

Do You Wear:
Glasses □ YES □ NO
Contacts □ YES □ NO

Are you Interested In:
Glasses □ YES □ NO
Contacts □ YES □ NO

HEALTH INFORMATION

Do you drink alcohol? □ YES □ NO
Do you smoke? □ YES □ NO Former smoker? □ YES □ NO

Have you had any eye surgeries? □ NO □ YES ; _____

If Yes, For what Condition: _____

Known allergies: _____

Do **you** or any **family members** have any of the following conditions?

Cataract	□ Self	□ Family Member: _____
Glaucoma	□ Self	□ Family Member: _____
Macular Degeneration	□ Self	□ Family Member: _____
Retinal Disease	□ Self	□ Family Member: _____
Lazy Eye	□ Self	□ Family Member: _____
Crossed Eye	□ Self	□ Family Member: _____
High Blood Pressure	□ Self	□ Family Member: _____
Diabetes	□ Self	□ Family Member: _____
Cancer	□ Self	□ Family Member: _____
High Cholesterol	□ Self	□ Family Member: _____
Other _____	□ Self	□ Family Member: _____

List current medications (including oral contraceptives, aspirin, over the counter and home remedies:

_____

_____

List Current Eyedrops: _____

PLEASE READ:

- I authorize payment of medical benefits to Greenwood Vision for services rendered.
- I understand that any quote given to this clinic by my insurance company is not a guarantee of payment. **Ultimate responsibility for verifying insurance coverage and eligibility rests with the patient.**
- I understand I am financially responsible for all charges for services rendered on my behalf or my dependents.
- 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 responsible for all fees.
- I understand there is a $25.00 returned check fee.
- I agree to pay any "co-pay" and any "co-insurance" at the time of service.
- I have read and understand the information provided above.

_____ Date: _____

Patient Signature

_____

Parent/Guardian Signature (If patient is under 18 years old):