Greenway Eye Care

Date: _____ Appointment Time: _____ Walk In Time: _____

Mr. Dr.
Mrs. Ms. _____ Parent/Guardian: _____
Last Name First Name Middle Initial

Address: _____ City _____ State _____ Zip Code _____

Date of Birth _____ Age _____ Occupation / Grade _____ E-Mail _____

Home Phone (_____) _____-_____Cell Phone (_____) _____-_____Approximate Date of Last Eye Exam_____

Doctor's Name _____ Location _____

Is this your first visit to Greenway Eye Care? _____ Yes _____ No Do You Wear Glasses? _____ Yes _____ No

Who or What Referred You to Greenway Eye Care?_____

Purpose for Today's Visit? _____

Have You Ever Worn Contact Lenses? _____ Yes _____ No If Yes, What Type of Lenses? _____

Are You Currently Still Wearing Contact Lenses? _____ Yes _____ No

Are You Interested in Being Fitted for Contact Lenses Today? _____ Yes _____ No If Yes, What Type? _____

GENERAL HEALTH				EYE HISTORY				CURRENT VISION PROBLEMS		
	YES	NO	IN FAMILY		YES	NO	IN FAMILY		YES	NO
Diabetes				Glaucoma				Blurry Vision at Distance		
Hypertension				Cataract				Blurry Vision Close-Up		
Heart Problems				"Lazy Eye"				"Halos" Around Lights		
Kidney Problems				Eye Injury				Poor Night Vision		
Thyroid Problems				Eye Surgery				Poor Color Vision		
Arthritis				Eye Infection				Flashes of Light		
Seasonal Allergies				Retinal Disease				Dry Eye		
Emphysema				Floaters or Spots				Seeing Double		
Cancer				Other:				Floaters or spots		
Other Problems:								Frequent Headaches		
								Watering Eyes		

List Known Allergies: _____

Medications Currently Being Taken & For What Conditions: _____
_____

Driver's License # _____ Social Security # _____Insurance Company: _____
Primary Member (If someone other than self): _____
Primary Insured Social Security #: _____ Primary Insured Date of Birth: _____

If you're unable to adapt to the new glasses prescription, we will gladly re-check the prescription within 30 days of the exam at no cost. After 30 days, there will be a Re-Check fee of $35.

For our contact lens patients, the fitting fee includes trials along with 2 follow up visits within 60 days. Any follow up there after, will incur a fee of $20/follow up during the 60 days. After 60 days, a new fit fee will be administered.

By signing this form, you hereby agree to be financially responsible for any and all charges incurred by you that your insurance does not cover in full.

X _____ Date _____
Signature of Patient or Parent/Guardian

Authorization and Consent

I certify that I have read and understand the Patient Form (dated _____) to the best of my knowledge. Any questions I had have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the doctor to release any information including the diagnosis and the records of any treatment of examination rendered to my child, or myself during the period of such eye care to third party payers and/or health practitioners. I further authorize any holder of any medical information about me to release any medical benefits provider information necessary to determine my eligibility and/or benefits.

I authorize and request my insurance company to pay directly to the eye doctor or ophthalmic group insurance benefits otherwise payable to me. I understand that my eyecare insurance carrier may pay less than the actual bill for services; therefore, I agree to be responsible for payment of the balance of all services rendered on my behalf or that of my dependants. Upon future visits to this practice, I will review the Patient Form and make all necessary changes and sigh and date a new Authorization. I have the right to revoke this authorization at any time by providing the practice with a signed written request. Until such as request is received, the Authorization will be in effect for six (6) years from the date of the most recent signed Authorization.

I have the right to expect my personal health information to be protected as outlined in the Notice of Private Practices below. The terms of the notice may change. If I desire, a copy of the new Notice will be provided to me by requesting one in writing from this practice. I can request to have my consent to use my Protected Health Information revoked at any time with a signed written request to this practice.

X _____ Date _____
Signature of Patient or Parent/Guardian

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please review it carefully.

Your point of contact about your rights to access your Health Records or complaints and comments about your health record privacy is:

HIPAA Director
3836 Richmond Ave
Houston, TX 77027

You may file a complaint with the director of HHS. We will use your Protected Health Information to provide appointment reminders, describe or recommend treatment alternatives and provide information about health related benefits and services that may be of interest to you. We will maintain the privacy of your health records, provide this Notice to you, abide by the terms of this Notice and reserve the right to revise the privacy practices of this office.

You have the right to review or to copy your health records, request changes to or offer amendments to your records, obtain a accounting of to whom we have disclosed information from your records and request restrictions on certain uses and disclosures from your health records. You also have the right to revoke our ability to disclose your health information by providing the practice with a signed written request. Until such a request is received, this Notice will be in effect for six (6) years from the date of the most recently signed Notice.

X _____ Date _____
Signature of Patient or Parent/Guardian

----------*For internal office use only*----------

_____ Patient declined dilation _____Patient declined Optomap Digital Retinal Imaging