Greenway Eye Care
Established Patient Form

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 _____ Social Security # _____

Occupation / Grade _____ E-Mail _____

Home Phone (_____) _____-_____ Cell Phone (_____) _____-_____ Business Phone (_____) _____-_____

Purpose for Today's Visit? _____

Are You Currently Wearing Contact Lenses or Interested in Being Fit in Them? _____ Yes _____ No

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

Other Family Members Who Are Patients of Ours:_____

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		
High Cholesterol				Floaters or Spots				Seeing Double		
Cancer				Macular Degen.				Floaters or spots		
Other Problems:				Other:				Frequent Headaches		
								Watering Eyes		

List Known Allergies: _____

Medications Currently Being Taken & For What Conditions: _____

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.

IF THE INSURANCE HAS CHANGED FROM YOUR LAST VISIT, PLEASE COMPLETE THE FOLLOWING:

Type of Insurance: (Please Circle) BCBS VSP Spectera Superior Vision Humana Vision (VCP)
Other: _____

Primary Member (If someone other than self): _____
Last Name First Name Middle Initial
Primary Insured Social Security #: _____ Primary Insured Date of Birth: _____

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.

_____ _____