Green Eye Associates, Vision Source

Leigh Anne Green, OD, FAAO, Optometric Glaucoma Specialist

General Information

First, Middle, Last Name

Preferred Name to be called

Street Address

City, State, Zip

Phone, type

Phone 2, type

Email

Preferred Contact Method:
□ Home □ Cell □ Text □ Email

Social Security Number

Date of Birth

Male/Female

Marital Status

Occupation/Employer

Language, Race, Ethnicity

How did you hear about us?

Insurance Information

Name of Vision Insurance Plan

Member Name

Member ID#

Member Date of Birth

Member Address (if different)

Name of Medical Insurance

Member Name

Member ID#

Member Date of Birth

Member Social Security Number

Group # (if listed)

Member Address (if different)

Member Employer

Your relationship to member

List any Secondary Insurance (if applicable)

Eye History

Date of Last Eye Exam

Previous Doctor (*if new patient*)

Primary Vision Correction:
□ Glasses □ Contacts □ None

Reason for Today's Visit?

Do you currently use any eye drops? If so, please list.

Have you ever undergone any eye surgery or experienced any traumatic eye injury? If so, please describe (what, when, etc.)

(***continued on back***)

Green Eye Associates, Vision Source

Eye History (cont.)

Have you or a family member been treated for any of the following? Circle all that apply.

Cataracts	*self*	*family*
Crossed Eyes	*self*	*family*
Glaucoma	*self*	*family*
Macular Degeneration	*self*	*family*
Retinal Detachment	*self*	*family*
LASIK/RK	*self*	*family*

Are you currently experiencing the following? Mark all that apply.

□ Blurry vision	*near*	*distance*
□ Burning		
□ Discharge		
□ Double vision		
□ Dryness		
□ Excess Tearing/Watering		
□ Eye Infection		
□ Eye Pain/Soreness		
□ Floaters/Spots		
□ Halos		
□ Headaches		
□ Itching		
□ Light Flashes		
□ Light Sensitivity		
□ Redness		
□ Sandy/Gritty Feeling		
□ Allergies		

Medical History

Have you or a family member been treated for the following? Circle all that apply.

Diabetes	*self*	*family*
Heart Disease	*self*	*family*
High Blood Pressure	*self*	*family*
High Cholesterol	*self*	*family*
Lupus	*self*	*family*
Stroke	*self*	*family*

Current Medications

Medication Drug Allergies

Name of Primary Care Provider/Doctor

Height:

Weight:

Pregnant or Nursing?

Do you smoke?

Have you ever smoked?

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have been made aware of Green Eye Associates, Notice of Privacy Practices, and release the right to file insurance given.

Date: _____

_____

Print Patient Name

_____

Signature

GREEN EYE ASSOCIATES