Date ____/____/____

Please print clearly

Patient Information

Marital Status ❒ Married ❒ Single ❒ Widowed ❒ Divorced Home phone # _____

Name _____ Cell phone # _____

Address _____ Soc. Sec. # _____

City _____ State _____ ZIP _____

Date of birth ____/____/____ E-mail address _____

Sex ❒ Male ❒ Female Do you live in a nursing facility? ❒ No ❒ Yes

Height _____ Weight _____ Date of admission to nursing facility ____/____/____

Name of nursing facility _____

Ethnicity ❒ Hispanic or Latino ❒ Not Hispanic or Latino ❒ Patient declined

Language preferred _____ ❒ Patient declined

Race ❒ American Indian or Alaska Native ❒ Asian ❒ Black or African American

❒ Native Hawaiian or other Pacific Islander ❒ White ❒ Patient declined

Employment Status

❒ Employed Employer _____ Phone # _____

❒ Retired Retired from (Company name) _____ ❒ Unemployed

Person to notify in case of emergency Name _____

(with phone number different from yours) Relationship _____ Phone # _____

May we leave a message with anyone at your home ❒ *Yes* ❒ *No* or on an answering machine ❒ *Yes* ❒ *No*?

Insurance Information

Please present your insurance cards to be copied. Primary _____

Secondary _____

In whose name is your insurance carried? _____ His/her date of birth ____/____/____

Referral Information

Whom may we thank for referring you to our practice?

Referring doctor / source _____ MD OD Phone # _____

Address _____ City _____ State _____ ZIP _____

Any other eye doctor _____

Primary care doctor _____ MD DO Phone # _____

Address _____ City _____ State _____ ZIP _____

Pharmacy (and address if known) _____

Do you have diabetes? ❒ *Yes* ❒ *No* If yes, name of the physician who manages your diabetes:

_____

SURGERIES: (Please list any surgeries)

Surgery: _____ Date: _____

Surgery: _____ Date: _____

Surgery: _____ Date: _____

OCULAR HISTORY

Have you ever had any of the following eye problems? (Please check Yes or No for each)

	NO	YES		No	Yes
Cataracts			Retinal Detachment		
Glaucoma			Macular Degeneration		
Lazy/Crossed Eyes			Diabetic Eye Disease		
Color Blindness			Dry Eyes		
Iritis			Eye Trauma		

Comment(s): _____

FAMILY HISTORY

	NO	**YES**		**No**	**Yes**
Diabetes			**Macular Degeneration**		
Glaucoma			**Retinal Detachment**		
Cataracts			**Corneal Disease**		

MEDICATIONS (PRESCRIPTION and NON- PRESCRIPTION)

NAME **DOSE (mg)** **FREQUENCY (i.e. once daily, twice daily)**

_____

_____

_____

_____

SOCIAL HISTORY

Marital Status: Single Married Divorced Widowed (Please Circle One)

Occupation: _____ Employer: _____

Do you consume alcohol? _____NO _____YES How Much? _____

Do you smoke or use tobacco? ____NO ____Yes How Much? _____

GREENMAN EYE ASSOCIATES

MEDICAL HISTORY QUESTIONNAIRE

PATIENT NAME: _____ DATE: _____

PATIENT DOB: _____ AGE: _____ GENDER: _____

PRIMARY CARE PHYSICIAN: _____ REFERRING DOCTOR: _____

REASON FOR VISIT: _____

PHARMACY NAME: _____ PHARMACY LOCATION/NUMBER: _____

DRUG ALLERGIES: YES OR NO If yes, list drug allergies and reaction: _____

List of current Medications: _____

PAST MEDICAL and SURGICAL HISTORY: (please check any medical problems, current or past)

_____Heart Disease

____Congestive Heart Failure

____High Blood Pressure/Hypertension (medication(s)) _____

____High Cholesterol (Medication(s)) _____

____Stroke or TIA

____Diabetes (Insulin, Medication)_____

____Gestational Diabetes

____Thyroid Disease

____Asthma

____COPD

____History of blood clots, DVT, pulmonary embolism

____Gastric Reflux Disease

____Arthritis

____Migraines, headaches

____Anemia

____Cancer

____Other

Greenman
EYE ASSOCIATES

2801 Randolph Road, Suite 200, Charlotte, NC 28211
704-375-2101 • Fax: 704-375-2107 • www.greenmaneyeassociates.com

AUTHORIZATION TO RECEIVE/RELEASE HEALTH INFORMATION

Due to the **HIPAA Compliance Privacy Laws of the Federal Government**, it is mandatory that we ask you to review and answer the following questions listed below.

Name: _____

May we leave messages/detailed medical information on voicemail at either of these phone numbers?

□ Yes □ No Home Phone: _____
□ Yes □ No Cell Phone: _____

May we contact you at your place of employment? □ Yes □ No
If so, may we leave a message? □ Yes □ No

If yes: Work Phone: _____ Extension: _____

Do you have any particular person or family members that you authorize to receive and discuss information regarding your personal health information (general information, surgical and billing)?

□ Yes □ No If yes, please provide:

Name: _____ Relationship: _____

Phone Number: _____

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I hereby authorize GREENMAN EYE ASSOCIATES to obtain or release any and all pertinent information regarding my medical care, as needed, to assist in my ongoing treatment to or from other health care providers, laboratories, radiology facilities or other institutions. This authorization remains in effect until revoked.

I have reviewed the aforementioned information and provide my consent regarding any and all the issues as stated above.

I have reviewed GREENMAN EYE ASSOCIATES Notice of HIPAA Privacy Policy. A copy of this policy will be provided to me upon request.

Patient Signature: _____ Date: _____

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FINANCIAL POLICY

We are committed to providing you with the highest level of service and quality care. If you have medical insurance, we will strive to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our financial policy. Ultimately, however, any and all financial liability rests with the patient.

Our office participates with most major insurance plans. We provide **MEDICAL and SURGICAL** ophthalmologic care to our patients. **If you have a managed care plan that requires a referral to see a specialist, you must obtain a referral in order for your visit in our office to be covered under your medical insurance.** If you do not have the valid referral and still wish to be seen, you will be asked to pay for the visit prior to your examination.

A refractive examination is not a covered service by most insurance companies, including Medicare. If you receive a prescription for glasses, you will be charged $ 45 which is payable at the time of the visit.

It is the patient's/parent's/guardian's responsibility to:

1. Be familiar with the benefits of your plan, including co-pays, co-insurance and deductibles.
2. Bring all of your current insurance cards to all visits.
3. Provide our office with current information including address, phone numbers and employer.
4. In accordance with your insurance contract, you must be prepared to pay your co-pay at each visit. We accept cash, checks and major credit cards for services.

We appreciate prompt payment in full for any outstanding balance. If your account is turned over to our collection agency, you agree to pay any fees imposed by the collection agency in order to collect the overdue amount. Any check payments that do not clear the bank will be subject to a **$25.00** returned check fee.

There is a charge for completing various forms, including your DMV form. Pre-payment is required for completing forms, or for extra written communication by the doctor. The charge is determined by the complexity of the form, letter, or communication.

MAXWELL GREENMAN, M.D. *Adult & Pediatric Ophthalmology • Laser Vision Correction • Cataract & Glaucoma Surgery • Eye Lid & Muscle Surgery*
DAVID GREENMAN, M.D. *Vitreo-Retinal Diseases • Macular Degeneration • Diabetic Retinopathy & Uveitis • Consultative Ophthalmology*
HERB GREENMAN, M.D. *Laser Vision Correction • Cataract & Glaucoma Surgery • Diabetic & Macular Degeneration • Plastic Surgery & Strabismus*

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For all services rendered to minor/dependent patients, we will look to the adult accompanying the patient and/or the parent or guardian with whom the child resides for payment. In cases of separation or divorce, when presenting insurance cards for a dependent enrolled under a subscriber other than you, please be prepared to supply their name, address, phone number, date of birth and social security number. We request that you inform the subscriber that their insurance has been used.

There will be a **$25.00** charge if you fail to show for any scheduled appointments or cancel the same day as your appointment. Any patient who cancels a scheduled, elective surgery without giving more than two (2) business days notice prior to surgery, or does not show up for surgery, will be charged a cancellation fee of **$100.00**. Legitimate emergencies will be taken into consideration.

I have read and understand the above financial policy.

_____ _____

Signature of patient/guardian/parent Date

_____ _____

Printed name of patient Date