Ironwood Eye Care – Dr. Gary H. Greene
10149 N. 92ND St., Ste. 102, Scottsdale, AZ 85258 Phone 480-860-1330

WELCOME TO OUR OFFICE! PLEASE FILL OUT THE FOLLOWING INFORMATION. THANK YOU!

Legal Name_____ M_/_F_ Today's Date____/_____/_____
Mr./Mrs./Ms./Dr. Last Name First Name MI Nickname/Suffix Sex

Address_____ Suite/Apt. #_____ City_____ State_____Zip_____

Birth date ____/____/____ SS# _____-____-_____ Home Phone_____ Cell Phone _____TXT OK?: Y / N
Parent / guardian if minor

Employment Status _____Occupation_____

Employed By _____ Work Phone_____

Email _____ Preferred Communication: Mail ☐ Email ☐ Phone ☐ Home/Cell/Work
(circle please)

Our office is required to collect the following information as part of a nationwide program to improve delivery of health care:

Race:
___ American Indian / Alaskan Native
___ Asian ___ Black/African American
___ Hispanic
___ Native Hawaiian /Other Pacific Island'r
___ White
___ Declined to answer

Ethnicity:
___ Hispanic or Latino
___ Not Hispanic or Latino
___ Declined to answer

Preferred Language:
___ English
___ Spanish

Marital Status: **S M D W Other** Parent/Spouse/S.O. Name _____ Phone_____

Referred by _____ Responsible party (besides insurance)_____

Emergency Contact Name _____ Phone _____

PURPOSE OF TODAY'S APPOINTMENT? CIRCLE: Routine, Lost / Broken Glasses, Expired Contacts Prescription
Decreased Vision / Eye Irritation / Infection: Onset _____Right Eye, Left Eye, Both Eyes
Date Time of day (if applies)

Other not listed above_____ _____

CONTACT LENS QUESTIONS: DO YOU CURRENTLY WEAR CONTACTS ? YES✱ / NO

IF YES: DO YOU WANT AN **UPDATED** CONTACT LENS PRESCRIPTION? YES✱ / NO

IF NO: WOULD YOU LIKE TO WEAR CONTACTS? YES✱/ NO ✱ ***additional fees for contact lens patients***

VISION INSURANCE COMPANY _____ ID #_____ or see card
Policyholder _____ Policyholder Birthdate ___/___/___ Relationship to Patient_____
PRIMARY MEDICAL INSURANCE COMPANY_____ ID# _____or see card
Policyholder _____ Policyholder Birthdate ___/___/___ Relationship to Patient_____
SECONDARY MEDICAL INSURANCE COMPANY_____ ID# _____ or see card
Policyholder _____ Policyholder Birthdate ___/___/___ Relationship to Patient_____

I authorize release of any medical or other information necessary to process an insurance claim and authorize direct payment of medical benefits to Dr. Gary H. Greene for the services rendered. I agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any services rendered. In the event that your account remains outstanding for 60 days after our office has initiated collection, your account will be referred to a licensed collection agency and assessed a **$25 collection fee**. In the event that my account is sent to collections, I agree to discuss my bill with the assigned agency. Refund Policy: no cash refunds on professional services or products. We reserve right to deny returns, subject to 30 day limit (office credit only).

I have read all the information on this sheet and have completed the above answers and certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or any of the above information. **$25 fee applies to all *returned checks*. *Cancelled/rescheduled appointments*** with less than a **24 business hour** notice MAY incur **a $25 cancel fee**.

Patient/Guardian Signature_____ Date_____

The above signature constitutes a signature on file for insurance purposes.

- Please turn this form over and complete side 2 -

IRONWOOD EYE CARE – DR. GARY H. GREENE
VISUAL AND MEDICAL HISTORY QUESTIONNAIRE

Name_____ Today's Date_____ Last Eye Exam_____

Name of Primary Care Physician_____ Phone # _____ Last Medical Exam_____

Preferred Pharmacy_____Address_____

Pharmacy Phone#_____

Family History:

Please note **family** history (parents, grandparents, siblings, children; living/deceased) for the following, and indicate relationship to you:

☐ Blindness_____ ☐ Retinal Disease_____ ☐ Diabetes_____ ☐ Thyroid Disease_____
☐ Macular Degeneration_____ ☐ Retinal Detachment_____ ☐ Heart Disease_____ ☐ High Blood Pressure_____
☐ Glaucoma_____ ☐ Cancer (type)_____ ☐ Cataract_____ ☐ Crossed/Drifting Eyes_____
☐ Other (Please explain):_____ ☐ **None of the above**

Medical History:

Do you have **any allergies to medications?** ☐ NO ☐ YES If yes, please list:

List any **medications or drugs** you take (including creams/ointments, eye drops, sprays/inhalers, oral contraceptives, aspirin, over the counter medications and home remedies) ***or provide written list***

List all **Eye Diseases/injuries/surgeries** (including infections, foreign objects in eye, Lasik /cataract surgeries) you have had:

Are you pregnant or nursing? ☐ NO ☐ YES

Do you wear glasses? ☐ NO ☐ YES Type: ☐ general wear ☐ Reading ☐ Computer ☐ Multifocal/Progressive ☐ Sunglasses

How old is your current pair of glasses? _____ Do you require safety glasses for occupation or sports? ☐ NO ☐ YES

Contact Lens Wearers: Type of contacts worn ☐ Rigid ☐ Soft Brand Name_____

Computer Usage - Average time spent at a computer: _____hrs/day Lighting: ☐ Fluorescent ☐ Incandescent ☐ Halogen

Are you experiencing any of the following symptoms while *at your computer*? (please check any that apply)
☐ Headaches ☐ Eye Strain ☐ Blurred Vision ☐ Dry/watery eyes ☐ Difficulty refocusing ☐ Double Vision ☐ Neck/shoulder Pain

Social History: *This information is kept strictly confidential. However you may discuss this portion directly with the doctor if you prefer.*
Do you drive? ☐ NO ☐ YES If yes, do you have visual difficulty when driving? ☐ NO ☐ YES

Do you drink moderate/heavy alcohol? ☐ NO ☐ YES. Do you have a history of substance abuse? ☐ NO ☐ YES

Do you use tobacco products? ☐ NO ☐ YES. Have you ever been infected with any sexually transmitted diseases? ☐ NO ☐ YES

Medical and Vision Status

Circle any of the following that **YOU** have had or currently have:

Allergies	High Cholesterol	Blurred Vision Far / Near	Glare, Light Sensitivity
Skin Problems	High Blood Pressure	Itchy Eyes	Flashes in Vision
Sinus Problems	Diabetes	Chronic Eye Infections	Floaters in Vision
Asthma	Thyroid Disorder	Excess Tearing/Discharge	Eye Pain
Neurological Problems	Cancer	Dry Eyes	Red Eyes
Seizures	Arthritis	Sties /Chalazion	Loss of Vision
Headaches/Migraines	Kidney Problems	Retinal Tear /Detachment	Motion Sickness
Vascular Disease	Emphysema	Glaucoma	Lazy Eye or Crossed Eyes
Anemia/Bleeding Problems	Hearing Problems	Cataracts	Double Vision
	Psychiatric Problems	Macular Degeneration	Drooping Eyelids
Other disease/condition not listed:			**None of the above**

_____ _____ Updated _____
Signature (patient or guardian) Date Initials/Date