

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!

Patient Name _____ Today's Date ___/___/___
 Mr./Mrs./Ms./Dr. Last Name First Name MI Nickname/Suffix
 Address _____ Suite/Apt. # _____ City _____ State _____ Zip _____

Home Phone _____ Daytime Phone _____ Cell Phone _____

Email address _____ Social Security # _____ - _____ - _____ Date of Birth ___/___/___ Sex M / F
(This pertains to parent/guardian if patient is a minor)

Vision Insurance Co. _____ ID # _____ Health Insurance Co. _____ ID# _____

Policyholder for Insurance Plan _____ Policyholder Birthdate ___/___/___ Relationship to Patient _____

Last eye exam _____ Hours of computer use per day _____ Occupation _____

Referred by _____ Responsible party (besides insurance) _____

Emergency Contact Name _____ Phone _____

What is the purpose of today's appointment ? Please Circle: *Routine, Eye Irritation, Lost Glasses, Expired CL Rx, Other* _____

Are you interested in laser eye surgery? YES / NO (no charge for screening)

Do you take prescription medications? YES / NO List _____

Are you allergic to any medications? YES / NO List: _____

Do you CURRENTLY have or have a HISTORY of any these CONDITONS or PROBLEMS WITH SYSTEMS listed?

	YES	NO		YES	NO		YES	NO		YES	NO
BLURRED FAR VISION <small>(WITH CURRENT GLASSES / CONTACTS)</small>			CATARACTS			EYE INJURY AND/OR SURGERY*			MACULAR DEGENERATION		
BLURRED NEAR VISION <small>(WITH CURRENT GLASSES / CONTACTS)</small>			DRY EYES and/or ITCHY EYES			GLAUCOMA			WATERY EYES		
ALCOHOL / SUBSTANCE ABUSE			ALLERGIES			ASTHMA / RESPIRATORY			HIGH BLOOD PRESSURE		
HEADACHES			TOBACCO USE			DIABETES			BLOOD / LYMPH		
CARDIOVASCULAR			ENDOCRINE/GLANDS			NERVOUS			OTHER _____		

*Details of injury/surgery (include date) _____

Is there a family history of any of the above? YES / NO List condition & relation to self _____

Name of Family Doctor _____ Doctor Phone Number _____

DO YOU CURRENTLY WEAR CONTACTS? YES / NO **IF NO: WOULD YOU LIKE TO? YES / NO**
(PLEASE NOTE: additional fees involved for contact lens patients)

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 and **any collection fees up to the amount of 50%** of outstanding charges. 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 or rescheduled appointments** with less than a 24-hour notice MAY incur a **\$25 cancellation fee**.

Patient/Guardian Signature _____ Date _____

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