STEVEN T. GREENHAW, M.D., P.C.
OPHTHALMOLOGY
HENRY H. BREWER III
OPTOMETRY
NEW PATIENT INFORMATION

Welcome to our office. We will do our best to make your appointment as pleasant and convenient as possible. Please complete the following questionnaire to the best of your ability: (Please Print)

PATIENT'S NAME ______ PHONE ( ) ______

ADDRESS ______ CITY ______ STATE ______ ZIP CODE ______

AGE ______ DATE OF BIRTH ______ SEX ______ S.S.# ______ MARITAL STATUS (Circle) SINGLE MARRIED DIVORCED WIDOWED

PLACE OF EMPLOYMENT ______ PHONE ______

NAME OF SPOUSE ______ PLACE OF EMPLOYMENT ______

IF PATIENT IS A MINOR:

MOTHER'S NAME ______ EMPLOYMENT ______ PHONE ( ) ______

FATHER'S NAME ______ EMPLOYMENT ______ PHONE ( ) ______

NAME OF FAMILY PHYSICIAN ______

WHO REFERRED YOU TO OUR OFFICE? ______

NAME AND ADDRESS OF PERSON FINANCIALLY RESPONSIBLE FOR THIS BILL IF DIFFERENT FROM ABOVE:

______

Person To Contact In Case of Emergency

NAME ______ PHONE ( ) ______ RELATIONSHIP ______

Insurance Coverage

	NAME OF INSURANCE	ID#	LIST OF PRIMARY & SECONDARY INSURANCE
MEDICARE			
OTHER			
WORKERS' COMP			

PAYMENT IS REQUIRED AT THE TIME SERVICES ARE RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE.

Method of payment: Cash ☐ Check ☐ Visa/Mastercard ☐

1. Steven T. Greenhaw, M.D., P.C. is granted permission to release to the insurance carrier, employer, attorney, their representatives or any treating physician, any information in connection with any treatment rendered to patient, or on patient's behalf anytime such information is requested.
2. Steven T. Greenhaw, M.D., P.C. is granted permission to obtain copies of diagnostic tests, i.e., lab work, EKG, Chest X-Ray, Ultrasound, CT Scan, etc. and other medical records from physicians and/or hospitals as deemed necessary.
3. I will pay Steven T. Greenhaw, M.D., P.C. for all services at the time they are rendered, including any non-covered services or deductibles, regardless of insurance coverage (except Medicaid), unless prior arrangements are made with the office manager. If such arrangements are approved, I authorize Steven T. Greenhaw, M.D., P.C. to secure any credit information deemed appropriate. If I do not pay my account within 30 days, interest of 1 1/2% per month will be charged on the unpaid balance, and I will be responsible for all costs of collection, including attorney fees.
4. By signing below, I certify that all information on this form is true and correct, and give you permission to examine and treat me.
5. If assignment is taken, I authorize payment of medical benefits to Steven T. Greenhaw, M.D., P.C.

DATE ______ SIGNATURE ______

Insured Person (or Parent, if Minor)

MEDICARE AUTHORIZATION

All Medicare patients must complete this section

Medicare law requirements state that all physicians must advise Medicare patients that there are some office procedures that are NOT covered under Medicare and that you will be responsible for payment for these procedures. In this office, these procedures include but are not limited to REFRACTION (automated or manual), routine eye exams (where there is not a medical or surgical problem), SCHIRMER TESTS (for dry eyes), KERATOMETRY and some CONTACT LENS charges. If there are others that are not listed, we will make every attempt to advise you in advance if possible. Please feel free to ask questions.

DATE ______ SIGNATURE ______

Insured Person (or Parent, if Minor)

-Continues On Reverse Side-

YOUR MEDICAL HISTORY IS IMPORTANT. PLEASE COMPLETE THE FOLLOWING CAREFULLY.

Reason for visit: ______________________________

____

HAVE YOU EVER HAD ANY OF THE FOLLOWING EYE PROBLEMS?

	YES	NO	WHEN?	TYPE & COMMENTS
1. Surgery	____	____	______	______
2. Eye Injury	____	____	______	______
3. Cataracts	____	____	______	______
4. Glaucoma	____	____	______	______
5. Dry Eyes	____	____	______	______
6. Floaters	____	____	______	______
7. Flashes of Light	____	____	______	______
8. Retinal Detachment	____	____	______	______
9. Retinal Degeneration	____	____	______	______
10. Sinus Problems/Allergies	____	____	______	______

Do You Wear Glasses? Yes______ No______ If Yes, how many years?______ How old are your present glasses?____

Are you pleased with them?______________________

Are you a contact lens wearer? Yes______ No______ If yes, how many years?______ Type of Lens ______

How often do you clean your lenses?______________________ Are they comfortable?______________

DO YOU HAVE ANY OF THE FOLLOWING MEDICAL PROBLEMS?

	YES	NO	HOW LONG?
1. Diabetes	____	____	______
2. High Blood Pressure	____	____	______
3. Heart Disease	____	____	______
4. Asthma	____	____	______
5. Arthritis	____	____	______
6. Bleeding Disorders	____	____	______
7. Cancer	____	____	______

8. Other______________________________

Are you allergic to any medications? Yes________ No________

If yes - list the medications and type reaction ______________________________

____

Current medications and dosages (including aspirin or blood thinners):

____

____

____

Personal physician: ______________________ **Last Time seen by this physician:** ______________________