Greenbaum Optometry
Robert S. Greenbaum, OD

Patient Information

Date:_____
Patient's Name:_____Birth Date:_____

Mailing Address: _____
City:_____ _____ State:____ Zip Code:_____
Home Phone: _____ Cell Phone:_____E-Mail :_____

Occupation:_____ Employer:_____
Work Address:_____
Work Phone: _____

SS#_____ Marital Status: _____

Person responsible for this account: _____ Phone #: _____ SS#:_____
Address:_____ City: _____ State:____ Zip Code:_____
Method of Payment Check_____ Cash_____ Credit Card _____ Insurance _____

Vision Insurance:_____ID#:_____Medical Insurance: _____ ID#: _____
Whom may we thank for referring you to our office? _____

HEALTH HISTORY: Reason for today's exam: _____
Date of last eye exam: _____ Last medical exam:_____ Family doctor and address:_____
_____

Do you or any blood relatives have a history of the following? If yes, indicate self or relative and relationship

YES	NO		YES	NO		YES	NO		YES	NO	
_____	___	Diabetes	_____	___	Hypertension	_____	___	Glaucoma	_____	__	Other
_____	___	Thyroid	_____	___	Turned eye	_____	___	Cataracts			
_____	___	Heart disease	_____	___	Lazy eye	_____	___	Macular degeneration			

Do any of the following conditions apply to you?

YES	NO		YES	NO		YES	NO		YES	NO	
___	___	Headaches	___	___	Sinus	___	___	Pregnant	___	___	High Cholesterol
___	___	Allergies	___	___	Drug allergies	___	___	Smoker			

List any medical conditions you may have: _____
List all medications you are taking, including over-the-counter: _____
_____
Have you ever had any of the following eye conditions?

YES	NO		YES	NO		YES	NO	
___	___	Surgery	___	___	Injury	___	___	Infection/Disease
___	___	Vision loss	___	___	Double vision	___	___	Eye strain
___	___	Distance blur	___	___	Near blur	___	___	Burn, Itch, Water

Do you work at a computer display terminal? _____
What hobbies or sports do you enjoy? _____
Do you currently wear glasses?_____ Contact lenses? _____ Type? _____
Are you interested in information about refractive laser surgery?_____

I request that payment of authorized Medicare benefits, and other authorized benefits be made either to me or on my behalf to the provider for services furnished to me. I authorize the release of medical information about me needed to determine payable benefits agree to be financially responsible for any services and/or materials provided by the doctor and this office that are not reimbursed by my insurance company.

Our office is dedicated to maintaining the privacy of your medical information. Please review or HIPPA privacy policy. Copies are available at the reception desk.

Signature of patient or legal guardian if a minor: _____