

Patient # \_\_\_\_\_

**WELCOME TO GREEN EYE CENTER**

If you are a New Patient, how did you hear about us?

Friend/Relative, whom may we thank? \_\_\_\_\_ Physician? \_\_\_\_\_

\_\_\_\_ Phonebook      \_\_\_\_ Newspaper      \_\_\_\_ TV      \_\_\_\_ Radio      \_\_\_\_ Screening/Seminar

**PATIENT INFORMATION: Please fill out ALL information completely and accurately.**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Home: ( ) \_\_\_\_\_ Work: ( ): \_\_\_\_\_ Cell: ( ) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

\_\_\_\_ Male    \_\_\_\_ Female      \_\_\_\_ Minor    \_\_\_\_ Married    \_\_\_\_ Single    \_\_\_\_ Widow    \_\_\_\_ Divorced

Employer's Name: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ ext: \_\_\_\_\_

Address/City/State/Zip: \_\_\_\_\_

**If the patient is a MINOR CHILD, complete the following section:**

**FATHER:**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Home: ( ) \_\_\_\_\_ Work: ( ): \_\_\_\_\_ Cell: ( ) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Employer's Name: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ ext: \_\_\_\_\_

Address/City/State/Zip: \_\_\_\_\_

**MOTHER:**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Home: ( ) \_\_\_\_\_ Work: ( ): \_\_\_\_\_ Cell: ( ) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Employer's Name: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ ext: \_\_\_\_\_

Address/City/State/Zip: \_\_\_\_\_

Patient # \_\_\_\_\_

**INSURANCE INFORMATION:**

**VISION INSURANCE: Place a check mark in front of the name of your insurance company.**

\_\_\_\_ VSP (Vision Service Plan)      \_\_\_\_ Eye Med      \_\_\_\_ SVS (Ford Employees)

Name of insurance, not listed above: \_\_\_\_\_

**Member's** Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Home: (    )                      Work: (    ):                      Cell: (    )

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

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**MEDICAL INSURANCE:**

**PRIMARY** Insurance Name: \_\_\_\_\_ ID#: \_\_\_\_\_ Group#: \_\_\_\_\_

**Member's** Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Home: (    )                      Work: (    ):                      Cell: (    )

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

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**SECONDARY** Insurance Name: \_\_\_\_\_ ID#: \_\_\_\_\_ Group#: \_\_\_\_\_

**Member's** Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Home: (    )                      Work: (    ):                      Cell: (    )

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

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Who would we notify in case of an emergency?

Name: \_\_\_\_\_ Relationship to the patient: \_\_\_\_\_

Home: (    )                      Work: (    ):                      Cell: (    )

**I authorize the release of all medical records maintained by Michael E. Green, MD which may be needed for my care or the processing of insurance claims. I authorize my insurance to make direct payment to Michael E. Green, MD. I understand that I am responsible for payment of any professional fees that are not covered by my insurance.**

Patient's Name: (Please Print): \_\_\_\_\_

Signature of Patient or Guardian: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Date: \_\_\_\_\_

