GRENE LASER

See Better, Live Better, Today

GENERAL INFORMATION: Today's Date ____/____/_______

Patient Name: ____
First Middle Last

How do you wish to be addressed? (e.g. – Mr., 1st Name, Nickname) ____

Social Security Number _____ - _____ - ______ Date of Birth: _____ / _____ / ______ Gender: □ M / □ F

Home Address: ____
Street City State Zip

Race: ______________________ Language: _____________________

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Unknown / Not Reported

Marital Status: □ Single □ Married □ Divorced □ Widowed

Home Phone: (_____) - _____ - ______ Cell Phone: (_____) - _____ - ______ Work Phone: (_____) - _____ - ______

Email address: _____________________________________

Your Occupation: _______________________ Employer: _______________________ Work #: (_____) - _____ - ______

Primary Care Physician: ___________________________ Eye Doctor: ___________________________

Emergency Contact: ______________________ Relationship: _________________ Phone: (_____) - _____ - ______

BILLING INFORMATION (If different from the patient):

Name of Person Financially Responsible for Account: ____

Relationship to Patient: _______________ SSN: ______ - ______ - ______ Date of Birth: ______ / ______ / _______

Home Phone: (_____) - _____ - ______ Cell Phone: (_____)- _____ - ______ Work Phone: (_____) - _____ - ______

Address: ____
Street City State Zip

I do hereby authorize the release of any medical information to process all claims, and request payment of any medical benefit to be paid to Grene Laser.

I have received the consent form, received a brochure entitled "Notice of Privacy Policies and Practices" and given my permission to Grene Laser to use and disclose my health information in accordance with the consent and the notice provided.

X ____________________________________ ___________________ _________________________________
Signature of Patient or Patient Representative Date Relationship of Patient Representative to Patient

ALLERGIES:

Drug / Material	Reaction
1. ________________	________________
2. ________________	________________
3. ________________	________________

	Circle	
Do you have a latex allergy?	Yes	No
Do you have adhesive / tape sensitivity?	Yes	No
Have you ever been diagnosed with a staph infection, or MRSA?	Yes	No

Please complete other side ☺

MEDICATIONS: (name and strength)

Prescription Medication Name	Taken For	Dosage (mg)	How Often

MEDICAL HISTORY (Your personal)

SYSTEMIC	**CIRCLE**	
Heart disease	yes	no
High Blood Pressure	yes	no
Stroke	yes	no
Cancer	yes	no
Lupus	yes	no
Rheumatoid arthritis	yes	no
Thyroid disease	yes	no
Seizures	yes	no
HIV / AIDS	yes	no

OCULAR	**CIRCLE**	
Double Vision	yes	no
Poor Night Vision	yes	no
Crossed / Lazy Eye(s)	yes	no
Dry Eyes	yes	no
Corneal Disease	yes	no
Herpetic ulcers	yes	no
Uveitis	yes	no
Glaucoma	yes	no
Macular Degeneration	yes	no
Retinal Detachment	yes	no

1) Diabetes: Yes No - If yes, what type of diabetes do you have? type 1 type 2

   Last A1C measurement _______ Last blood sugar measurement ______ Year diagnosed ________________

2) Autoimmune Disease (not listed above): Yes No - If yes, what disease ________________________________
3) Are you pregnant or nursing: Yes No
4) Any other ailment(s) you would like to list: ____

SURGERIES / INJURIES: Please include any eye surgeries

Incident	Date Occurred	Doctor

FAMILY HISTORY: Family history applies to (parents, grandparents, siblings, children, living or deceased)
If someone in your family is affected by a listed condition please list your relationship.

SYSTEMIC	Relationship	OCULAR	Relationship
Diabetes		Blindness	
Heart Disease		Corneal Disease	
High Blood Pressure		Corneal Transplant	
Stroke		Crossed/Lazy Eyes	
Cancer		Glaucoma	
Lupus		Cataracts	
Rheumatoid Arthritis		Retinal Detachment	
Thyroid Disease		Macular Degeneration	

SOCIAL HISTORY

Have you used tobacco products? Yes No If yes, do you currently use tobacco products? Yes No

Please list the type of tobacco product & amount used per week: ___________________________________

Do you consume alcohol? Yes No Formerly If yes, average number of drinks you have per week? _____