Medical: _____ **NP / EP** **Vision:** _____ **Copay $**_____
Copay $_____ **Retinal Imaging $ 39.00**
MPOD $_____ **MPOD $**_____ **Contacts Lens $**_____
Total $_____ **Total $**_____

Date _____ Arrival Time _____

How did you hear about us: _____

Patient Information ***(As it appears on your insurance card)***

Patients First Name_____ **Middle**_____ **Last**_____

Nickname _____ **M / F** **DOB** ___/____/_____ **Marital Status S / M / W/ D**

Address _____ **City**_____ **State**_____ **Zip** _____

Employer: _____ **Occupation:** _____

Primary Care Doctor: _____ **Address & Phone:** _____

Pharmacy: _____ **Address:** _____ **Phone:** _____

Reason for today's visit _____ Date of last eye exam_____

Contact Information **May we leave a detailed message on your phone?** _____ C ☐ W ☐ H ☐

Phone: Cell (____)_____ **Work (____)**_____ **Home: (____)**_____

Email address: _____

Medical History

Height: _____ Weight:_____ **Epileptic Y / N** **Diabetic Y / N**

Drinking: never/ occasionally/ often **Tobacco/Nicotine:** never/ former/current

Do you currently wear contacts? Y / N **Interested or would like more information about contacts?** Y/ N

Quantifeye: ZeaVision has developed a 3-part Macular Degeneration Risk Management program consisting of an assessment of risk factors, a measurement of Macular Pigment Optical Density (MPOD), and a retinal examination – all conducted by an eye care professional. We recommend this procedure for every adult patient. It is especially important for people who have a family history of AMD. This is not covered by your insurance.

The cost for this service is $30.00. **Perform this service: Y / N**

Would you like to have genetic testing for Macular Degeneration? Y/N

With my signature, I authorize treatment by Dr. Lisa M. Greene, OD PA and staff. I understand I am financially responsible for all charges and any services rendered including, if applicable, the balance remaining after possible insurance benefits. I authorize the staff at Dr. Lisa M. Greene, OD PA to act on my behalf regarding services received in their offices. I authorize the release of any medical information necessary to process my insurance claim. I assign and request that insurance payments be made directly to Dr. Lisa M. Greene, OD PA. This office is HIPAA compliant. A copy of the Privacy Information Practice is available at your request. It is your responsibility to read and understand your own insurance policy. Certain services and procedures may or may not be covered by your insurance. It is your responsibility to contact your insurance company to find out whether Dr. Lisa M. Greene is a participation provider. In closing, insurance information must be presented at the time of service. **Our returned check fee is $35.00**.

In the event the account becomes delinquent, requiring collections assistance and/or an attorney, I understand that I am responsible for these fees.

Signature _____ **Date** _____