Greenberg Laser Eye Center

3001 W. Big Beaver Rd., Ste. 105, Troy, MI 48084
(248) 649-2820 fax (248) 649-1444 www.greenbergeye.com vision@greenbergeye.com

Name: _____
Address:_____
City:_____ State:_____ Zip:_____
Telephone #: Home: ( )_____ Work: ( )_____
Date of Birth:_____ Age:_____ Cell: ( )_____
Gender: M F Marital Status: S M D W
Social Security #:_____
Personal Email:_____
Occupation:_____
Employer:_____
Address:_____ Telephone#: ( )_____
City:_____ State: _____ Zip:_____
Financially Responsible Person:_____ Telephone#: ( )_____
Address:_____City:_____ State:_____ Zip:_____
Employer:_____
Name of nearest relative not living with you:_____
Address:_____ Telephone#: ( )_____
Family Physician:__ _____ Telephone#: (_____)_____

Whom may we thank for referring you to our office?
Name_____

Address_____

1. When was your last eye exam?_____ Last Dr.:_____
2. How many pairs of glasses do you have? _____ How many do you use?_____
3. Do you wear contact lenses? Yes No
Brand:_____ Prescribed by:_____

To comply with the Affordable Care Act, we are required to ask you the following questions:

Race: ___ American Indian or Alaska Native ___ Asian ___ African American ____Caucasian
_____ Native Hawaiian or Other Pacific Islander Other _____

Ethnicity: ____ Hispanic ____Non-Hispanic

Preferred Language: English French Italian Japanese Portuguese Russian Spanish

Primary Care Doctor:_____

Endocrinologist:_____ Rheumatologist:_____

Pharmacy Name:_____ Pharmacy Phone#:_____

Pharmacy location (Street & City):_____

HIPAA -This office complies with the most recent HIPAA Privacy and Security Act. I have been offered a copy of the new 2013 HIPAA Omnibus Rules.

Do we have your permission to address you by your last name in the waiting room? **Y N**
Do we have your permission to leave a message at the given numbers regarding appointments? **Y N**
Do we have your permission to leave a message at the given numbers regarding billing questions? **Y N**
Do we have your permission to leave message/mail/email/text you about appointments/reminders? **Y N**

I hereby authorize the release of any medical information necessary to process this claim. I understand I am responsible for payment of all copays, deductibles, or non-covered procedures.

Signed:_____ Relationship:_____ Date:_____