

**Wilson, Greidinger and Mullin**  
*Welcome to our Office*

PLEASE PRINT - COMPLETE ALL INFORMATION

Lawrence Account # \_\_\_\_\_

**Patient Information**

Mullin Account # \_\_\_\_\_

Circle one - Mr. Mrs. Miss Master Ms. Other \_\_\_\_\_

Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ D.O.B \_\_\_\_/\_\_\_\_/\_\_\_\_

Home Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Sex M or F SS# \_\_\_\_\_

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

Spouse (or parents of Child) \_\_\_\_\_ Email Address \_\_\_\_\_@\_\_\_\_\_

Employer (School) \_\_\_\_\_ Occupation: \_\_\_\_\_

Primary Physician \_\_\_\_\_ Dr's Phone ( ) \_\_\_\_\_ Dr's Fax # ( ) \_\_\_\_\_

Physician's Address: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Pharmacy Phone# ( ) \_\_\_\_\_

Previous Eye Doctor: \_\_\_\_\_ Date of Last Eye Exam: \_\_\_\_\_

Whom may we thank for referring you: \_\_\_\_\_

**Medical Insurance Information**

**Primary Insurance Co:** \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber's S.S. # \_\_\_\_\_

Claims Address \_\_\_\_\_

Subscriber \_\_\_\_\_ D.O.B \_\_\_\_/\_\_\_\_/\_\_\_\_ Relationship \_\_\_\_\_

Subscriber's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Subscriber's Telephone # \_\_\_\_\_ Subscriber's Cell Phone # \_\_\_\_\_

**Secondary Insurance Co:** \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber's S.S.# \_\_\_\_\_

Claims Address \_\_\_\_\_

Subscriber \_\_\_\_\_ D.O.B \_\_\_\_/\_\_\_\_/\_\_\_\_ Relationship \_\_\_\_\_

Subscriber's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Subscriber's Telephone # \_\_\_\_\_ Subscriber's Cell Phone # \_\_\_\_\_

**Vision Insurance Co:** \_\_\_\_\_

Policy # \_\_\_\_\_ Subscriber's Social Security # \_\_\_\_\_

Claims Address \_\_\_\_\_

Subscriber \_\_\_\_\_ D.O.B \_\_\_\_\_ Relationship \_\_\_\_\_

Subscriber's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Subscriber's Telephone # \_\_\_\_\_ Subscriber's Cell Phone # \_\_\_\_\_

Does your Vision Insurance cover \_\_\_\_\_ Glasses Y/N \_\_\_\_\_ Contacts Y/N \_\_\_\_\_

**\*If my health insurance provider does not provide full reimbursement for services rendered, the balance of payments is my responsibility.**

**I authorize the release of any medical information necessary to process all insurance claims.**

**I authorize the release of payment for benefits to WILSON, GREIDINGER and MULLIN**

**Date:** \_\_\_\_\_ **Name:** \_\_\_\_\_

**Social History**

Do you Drive? Yes No If yes, do you have visual difficulty when driving? Yes No (Please describe) \_\_\_\_\_

Do you use tobacco products? Yes No Type/Amount/How Long: \_\_\_\_\_

Do you drink alcohol? Yes No Type/Amount/How Long: \_\_\_\_\_

**Medical History**

Do you have any allergies? \_\_\_\_\_

Do you have any allergies to any medications? \_\_\_\_\_

List any medications you take (including oral contraceptives, aspirin, over the counter medications, home remedies and all *eye drops*)? \_\_\_\_\_

Do you have any medical problems? \_\_\_\_\_

Have you ever been exposed to or infected with: Hepatitis HIV

List all major surgeries, injuries and/or hospitalizations you have had: \_\_\_\_\_

Do you or any blood relative ever have the following:

<b>Ocular</b>	<b>Self</b>	<b>Relative</b>	<b>Medical</b>	<b>Self</b>	<b>Relative</b>
<input type="checkbox"/> Cataracts	_____	_____	<input type="checkbox"/> Diabetes	_____	_____
<input type="checkbox"/> Glaucoma	_____	_____	<input type="checkbox"/> High Blood Pressure	_____	_____
<input type="checkbox"/> Retinal Detachment/Disease	_____	_____	<input type="checkbox"/> Arthritis	_____	_____
<input type="checkbox"/> Blindness	_____	_____	<input type="checkbox"/> Allergies	_____	_____
<input type="checkbox"/> Crossed Eye	_____	_____	<input type="checkbox"/> Asthma	_____	_____
<input type="checkbox"/> Lazy Eye	_____	_____	<input type="checkbox"/> Lung Disease	_____	_____
<input type="checkbox"/> Drooping Eye	_____	_____	<input type="checkbox"/> Cancer	_____	_____
<input type="checkbox"/> Prominent Eyes	_____	_____	<input type="checkbox"/> Kidney Disease	_____	_____
<input type="checkbox"/> Eye Infection	_____	_____	<input type="checkbox"/> Thyroid Disease	_____	_____
<input type="checkbox"/> Eye Injury	_____	_____	<input type="checkbox"/> Heart Disease	_____	_____
<input type="checkbox"/> Loss of Vision	_____	_____	<input type="checkbox"/> Depression	_____	_____
<input type="checkbox"/> Blurred Vision	_____	_____	<input type="checkbox"/> Anxiety	_____	_____
<input type="checkbox"/> Distorted Vision	_____	_____	<input type="checkbox"/> Skin Disorder	_____	_____
<input type="checkbox"/> Double Vision	_____	_____	<input type="checkbox"/> Cholesterol	_____	_____
<input type="checkbox"/> Halos	_____	_____	<input type="checkbox"/> Headaches	_____	_____
<input type="checkbox"/> Flashes or Floaters	_____	_____	<input type="checkbox"/> Migranes	_____	_____
<input type="checkbox"/> Dryness	_____	_____	<input type="checkbox"/> Other _____	_____	_____
<input type="checkbox"/> Sandy Feeling/Pain	_____	_____	<input type="checkbox"/> Other _____	_____	_____
<input type="checkbox"/> Tearing/Discharge	_____	_____			
<input type="checkbox"/> Glare/Light Sensitivity	_____	_____			
<input type="checkbox"/> Styes/Chalazians	_____	_____			

Do you presently wear glasses? \_\_\_\_\_ How old are your present pair of glasses? \_\_\_\_\_

Do you presently wear contacts? \_\_\_\_\_ How old are your present pair of lenese? \_\_\_\_\_

Type of contacts lenses: \_\_\_ Gas Perm \_\_\_ Soft \_\_\_ 2 week - Disposable \_\_\_ Monthly Disposable \_\_\_ Daily Disposable

Current Contact Lense Problems or Complaints: \_\_\_\_\_

Date: \_\_\_\_\_ Pt. Signature \_\_\_\_\_ Dr. Signature \_\_\_\_\_

