

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 _____ Email Address _____

Home Phone# () _____ Cell Phone: () _____ Work Phone # () _____

Name of Spouse (or parents of Child) _____ Sex: M or F SS# _____

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: [All negative, except as noted]

Ocular	Self	Relative	Medical	Self	Relative
<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 _____