Lawrenceville Eye Care, LLC
Welcome to our Office

PLEASE PRINT - COMPLETE ALL INFORMATION HIPAA/EMR RECORDS COMPLIANT

We understand that some of the following questions are personal – All information is kept confidential.

LEC Account # _____

Patient Information **Mullin Account # _____**

Circle one –

Salutation - Mr. Mrs. Miss Master Ms. Dr. Other _

Marital Status - Single Married Separated Divorced Widowed Common Law Domestic Partner

Last Name _____ First _____ MI_____

Nickname: _____ D.O.B _____/_____/_____ Birth State _____

Home Address:_____

City_____ State _____ Zip _____ Sex M or F SS# _____

Home Phone# ( )_____Cell Phone: ( ) _____ Carrier _____

Work Phone # ( ) _____ Ext_____ Contact Preference - Home Cell Work

Email Address: _____@_____._____

Parents/Spouse: _____

Account Responsible Name: _____ Relationship _____

Patient's Employer (School)_____Occupation: _____

Primary Physician_____

Dr's Phone ( )_____ Dr's Fax # ( ) _____

Physician's Address: _____

Pharmacy Name:_____ Pharmacy Phone# ( ) _____

Mail Order Pharmacy: _____ Pharm Preference - Mail Order/Pharmacy

Previous Eye Doctor: _____ Date of Last Eye Exam:_____

Please circle one of the following……

Primary Language: English Spanish French Other: _____

Race: White/Caucasian Hawaiian or Pacific Islander American Indian_ Alaska Native Asian African American__ Other: _____ Refuse to Answer

Ethnicity: Not Hispanic or Latino Hispanic or Latino Unknown Refuse to Answer

Special Needs: Hearing Impaired Translator Wheel chair Other: _____

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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 # _____

Tertiary 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 Lawrenceville Eyecare, LLC or Dr. Guy S. Mullin

Date: _____ **Name:** _____

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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: (Negative – unless otherwise noted)

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

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 lenses? _____

Type of contacts lenses: ___ Gas Perm __ Soft __ 2 week - Disposable __Monthly Disposable __ Daily Disposable

Current Contact Lens Problems or Complaints: _____

_____

Date: _____ Pt. Signature_____ Dr. Signature _____

Signature Sheet
Lawrenceville Eye Care, LLC
and Dr. Mullin

I understand that the information that I have provided is accurate. It is my responsibility to inform the doctor's office of any changes in my medical status. I have reviewed all the information on these forms and confirm that it have been updated to the best of my knowledge. I understand that I am financially responsible for all charges for services to me (or my dependents), including the balance after payment or denial from my insurance company. It is my responsibility to understand my insurance and provide the necessary information or referrals at the time of my visit. I understand my signature requests that payments be made and authorized release of medical information necessary to pay the claim.

Signature	Date

Lawrenceville Eye Care, LLC and Dr. Mullin

Receipt of Notice of Privacy Practices is hereby acknowledged:

Signature of Patient or Guardian: _____

Print Name: _____ **Relationship:** _____

Date: _____

HIPPA Contact Release Information: I grant permission to share or disclose my information with:

_____ **Relationship:** _____

_____ **Relationship:** _____

_____ **Relationship:** _____

If signed by a guardian or Power of Attorney, name of patient:

_____

The patient, or person signing for the patient named above, acknowledges receipt of a federally required Notice of Privacy Practices, provided to you under the provisions of the Health Insurance Portability and Accountability Act of 1996. The Notice describes how medical information about you (or the patient, if you are someone signing for the patient) may be used and disclosed, and how you can get access to this information. You also have certain other privacy rights under federal law, and these rights are described more fully in the notice. You may request a copy for you to take with you, for your review. The Notice helps you understand all the uses and disclosures that may be made of your medical information, and it describes your privacy rights. The Notice also indicates who you should contact if you have any questions about your privacy rights. This receipt will be kept in your record to document you have received this Notice.