A Beacon of Light For Your Best Eye Sight

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Welcome to our office. Please complete all information including Patient & Insurance Information, as well as Medical Information on the reverse side.

Patient Information

Today's Date ________________ ❑Mr ❑Ms ❑Mrs ❑Miss ❑Dr

Last Name_______________First Name_______________MI_____

Street ______________________________Apt#________________

City______________________ State______ Zip________________

Are you a full time Florida resident? YES or NO

What is your HOME phone number?__________________________

What is your CELL number?______________________________

Which is the best # to call you on?___________________________

Email address____

How do you prefer we contact you?

❑Email ❑ Phone ❑Text ❑Mail

Sex ❑M ❑F DOB______/______/_______ Age__________

SS #_______-_____-_______ Marital Status ❑S ❑M ❑________

Employment Status FT PT N/A Occupation_________________

Employer_______________________ Ph# ___________________

Reason(s) for today's visit?________________________________

____

How did you hear about us?

Were you REFERRED to us? If yes, we'd like to thank them! Please indicate who (NAME).

____

ASK ABOUT OUR REFERRAL INCENTIVE PROGRAM

I was NOT Referred, I Found You by:

❑Walk In–New to Office ❑Walk In–Established Customer

❑Insurance ❑Our Website ❑Other Website ❑Direct Mailing

❑Newspaper Ad ❑Yellow Pages ❑Groupon ❑Event

❑Social Media ❑ Other ____________________________

Other____

Insurance Information

Primary Medical Insurance________________________________

Primary Insured? ❑Patient ❑Spouse ❑Parent/Guardian ❑Child

Insured Name:___________________________DOB____________

ID #__________________________SS # _______-_____-_______

Secondary Medical Insurance______________________________

Primary Insured? ❑Patient ❑Spouse ❑Parent/Guardian ❑Child

Insured Name:___________________________DOB____________

ID #__________________________SS # _______-_____-_______

Vision Insurance____

Primary Insured? ❑Patient ❑Spouse ❑Parent/Guardian ❑Child

Insured Name:___________________________DOB____________

ID #__________________________SS # _______-_____-_______

Digital Retinal Camera Consent

Retinal Photos are available to all patients & assist in the evaluation of your overall health & eye health. They are highly recommended for all patients to aid in the detection of health conditions & eye disorders, particularly if you:

- **Would like a permanent, baseline record of your current eye health or condition(s)**
- **Have a strong prescription**
- **Are over 40 years old**
- **Have frequent headaches or see spots or flashes of light**
- **Have high blood pressure, high cholesterol, or diabetes**
- **Have a family history of glaucoma, diabetes, high blood pressure, cholesterol, or macular degeneration**

Your medical/vision insurance benefits may cover the fee for Retinal Photos if you have underlying medical condition(s) determined at the conclusion of your exam. If there is no insurance coverage, our fee is $35.

Initial One:

□ Yes, I would like the photos taken

□ Unsure, I would like to discuss further with Dr. Lessly

□ No, I do not want the photos taken at this time

OUR COMMITMENT TO YOU

At Inlet Optical Eye Care we strive to make a positive difference in our patients' healthcare and how they see their world. It's our commitment to provide superior care and service, quality products with advanced technology, and a professional eye care team to ensure your complete satisfaction.

Welcome To Our Office
Please complete all information as it's critical to the evaluation of your health & vision.

Medical & Social History

Name of Primary Care Dr ________________________________

City _________________________ Ph___________________

Date of Last Physical Check-up _______/_______/________

Are you pregnant? ❑Yes ❑No How many months? ________

Have you had any surgeries? ❑Yes ❑ No Please explain______

____

CURRENT MEDICATIONS (Prescription & Over The Counter)

(Record or attach list of meds. including eye drops, vitamins, birth control pills) _________________________________

____

Allergies to medications? ❑Yes ❑No Which? What happened? When? ____

____

Your Height________________ Your Weight_______________

Have you ever used tobacco? ❑Yes ❑No Currently? __________

Current Alcohol Use? ❑Yes ❑No How much per day?_________

Have you ever been diagnosed or treated for any of the Following? (Check if Yes)

❑ Anxiety/Depression	❑ Genitourinary
❑ Allergies	❑ Heart
❑ Arthritis	❑ High Blood Pressure
❑ Blood/Lymph	❑ Integumentary (Skin)
❑ Bronchitis	❑ Kidney
❑ Cancer	❑ Migraines/Headaches
❑ Cholesterol	❑ Muscle/Bone
❑ Diabetes	❑ Neurological
❑ Digestive	❑ Psychological
❑ Ears/Nose/Throat	❑ Respiratory
❑ Endocrine	❑ Sinus
❑ Eczema/Rashes	❑ Throat Infections
❑ Fatigue	❑ Thyroid
❑ Fevers	❑ Unusual weight loss / gain

Has a family member been diagnosed with the following? (Check if Yes and list Who)

❑Blindness________________	❑Glaucoma________________
❑Cancer__________________	❑Hypertension_____________
❑Cataracts________________	❑Lazy Eye________________
❑Heart Disease_____________	❑High Cholesterol__________
❑Diabetes________________	❑Corneal Issues___________
❑Macular Degeneration_______	❑Retinal Problems__________

Lifestyle History

Do you…(Check box if your answer is Yes)

❑..work at a computer ___________ Hrs/week
❑..experience problems with glare when wearing glasses
❑..spend a good amount of time outside ___________ Hrs/week
❑..prefer not to wear your eyeglasses at times
❑..have a need for a second or backup pair of Rx glasses

Medical & Eye History

Date of Last Eye Exam____/____/_____ Dr.____________________

Do you wear Glasses? ❑Yes ❑No

Lens Type? ❑Single Vision ❑Progressive ❑Bifocal ❑Trifocal

Are you satisfied with your lens type(s)? ❑Yes ❑No

If no, why?____

Have you ever tried Contact Lenses? ❑Yes ❑No

Do you currently wear Contact Lenses? ❑Yes ❑No

If yes, what kind? _____________________________________

How many hrs/day?______ How often do you replace them?______

Solutions used?_______________________________________

Are you satisfied with the vision and comfort of your contacts?

❑Yes ❑No If no, why?____________________________________

Have you experienced, been diagnosed with or treated for any of the following? (Check if Yes)

❑ Blurry Vision	❑ Uncomfortable Glasses
❑ Itching Eyes	❑ Trouble Seeing at Night
❑ Tearing Eyes	❑ Double Vision
❑ Burning Eyes	❑ Eye Injury
❑ Flashes of Light	❑ Corneal Abrasions
❑ Floaters/Spots	❑ Retinal Detachment
❑ Dryness in Your Eyes	❑ Glaucoma
❑ Sensitivity to Sunlight	❑ Cataracts
❑ Painful Light Sensitivity	❑ Macular Degeneration
❑ Grittiness in Eyes	❑ Lazy Eye
❑ Eye Infections	❑ Crossed Eye/Turning Eye
❑ Frequent or Severe Headaches	❑ Other Eye Disorder(s)

Other? ____

HIPPA Notice of Privacy Practices & Financial Agreement

I,_________________________(print name) have been/will be presented with the Notice of Privacy Practices of Inlet Optical Eye Care. I acknowledge that I have been/will be offered a copy for my records_____ (please initial). I agree that if I refuse receipt of the Notice, Provider(s) at Inlet Optical Eye Care may still provide treatment for me.

Your insurance is a contract between you and your insurance company. We are not a party to that contract. Not all services or materials are covered benefits under insurance contracts. All non-covered services or materials are the financial responsibility of the patient, including the refraction fee of $35 when medical insurance benefits are used.

Please understand that we do our best to accurately estimate your insurance benefits but it is an estimate only and we our bound by what your insurance company accepts or denies.

I acknowledge that it is my responsibility to pay any deductibles, co-pays, co-insurance, or any other balance not paid for by my insurance company. If your account is assigned to a third party for collection, the prevailing party shall be entitled to all costs of the collection process.

Signature________________________________ Date______________