



A Beacon of Light For Your Best Eye Sight

**Dr. Michael Lessly • 103 S. US Highway 1, B-2 • Jupiter, FL 33477
561-746-5910 (ph) • 561-746-3268 (fax) • www.jupiterinleteyes.com**

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? _____
 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? _____

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 \$39.

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

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 _____

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)

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

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

- | | |
|-----------------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Blindness _____ | <input type="checkbox"/> Glaucoma _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Hypertension _____ |
| <input type="checkbox"/> Cataracts _____ | <input type="checkbox"/> Lazy Eye _____ |
| <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> High Cholesterol _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Corneal Issues _____ |
| <input type="checkbox"/> Macular Degeneration _____ | <input type="checkbox"/> 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)

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

HIPPA Notice of Privacy Practices & Financial Agreement

I 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. 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 _____