INLET OPTICAL
EYE CARE CENTER

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 _____

Last Name_____

First Name _____MI_____ ❑Mr ❑Ms ❑Dr

Street _____

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?_____

Is there an alternative # 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 ❑M ❑S

Employment Status _____ Occupation_____

Employer_____ Ph# _____

Date of last Eye Exam? _____/_____/_____

Reason(s) for today's visit?_____

_____

_____

Any problems with your current glasses or contacts? ❑Y ❑N

If yes, what? _____

_____

_____

Insurance Information

Primary Medical Insurance_____

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

Insured Name:_____

ID #_____

DOB _____ SS # _____-_____-_____

Secondary Medical Insurance_____

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

Insured Name:_____

ID #_____

DOB _____ SS # _____-_____-_____

Vision Insurance_____

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

Insured Name:_____

ID #_____

DOB _____ SS # _____-_____-_____

How did you hear about us?

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

_____

Current Patient /Customer Dr / Professional Family / Friend

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 _____

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 _____

Town _____ 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
- ❑ Allergies
- ❑ Arthritis
- ❑ Blood/Lymph
- ❑ Bronchitis
- ❑ Cancer
- ❑ Cholesterol
- ❑ Diabetes
- ❑ Digestive
- ❑ Ears/Nose/Throat
- ❑ Endocrine
- ❑ Eczema/Rashes
- ❑ Fatigue
- ❑ Genitourinary
- ❑ Heart
- ❑ High Blood Pressure
- ❑ Integumentary (Skin)
- ❑ Kidney
- ❑ Migraines/Headaches
- ❑ Muscle/Bone
- ❑ Neurological
- ❑ Psychological
- ❑ Respiratory
- ❑ Sinus
- ❑ Throat Infections
- ❑ Thyroid

Lifestyle History

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

- ❑..work at a computer _____ Hrs/week
- ❑..think you would benefit from thinner, lighter lenses
- ❑..experience problems with glare when wearing glasses
- ❑..have interest in a "trial" of the latest contact lenses
- ❑..spend a good amount of time outside _____ Hrs/week
- ❑..have Rx sunglasses
- ❑..have other sun protection for your eyes_____
- ❑..use sunglasses/eye sun protection when driving
- ❑..prefer not to wear your eyeglasses at times
- ❑..have a need for a second or backup pair of Rx glasses
- ❑..have family members in need of eye care_____

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

Other? _____

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

❑Blindness	_____	❑Glaucoma	_____
❑Cancer	_____	❑Hypertension	_____
❑Cataracts	_____	❑Heart Disease	_____
❑High Cholesterol	_____	❑Lazy Eye	_____
❑Corneal Issues	_____	❑Macular Degeneration	_____
❑Diabetes	_____	❑Retinal Problems	_____

HIPPA Notice of Privacy Practices

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.

Signature_____ Date_____