



Jennifer M. Lesslie, OD

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PLEASE FILL OUT FORM COMPLETELY

Last _____ First _____ MI _____ Male ___ Female ___
 Address _____ City _____ State _____ Zip Code _____
 Home Phone _____ Work Phone _____ Cell Phone _____
 Email Address _____ SSN _____ Date of Birth _____
 Height _____ Weight _____ Marital Status: ___ Married ___ Single ___ Widowed ___ Divorced ___ Separated
 Employer _____ Occupation _____
 Spouse/Guardian's Name _____ Spouse/Guardian's Employer _____

Vision Insurance: _____
 Policy Holder's Name: _____
 Policy Holder's Date of Birth: _____
 Policy Holder's SSN: _____

Preferred Pharmacy / Zipcode

Secondary Medical Insurance: _____
 Policy Holder's Name: _____
 Policy Holder's Date of Birth: _____
 Policy Holder's SSN: _____

Primary Medical Insurance: _____
 Policy Holder's Name: _____
 Policy Holder's Date of Birth: _____
 Policy Holder's SSN: _____

Who may we thank for referring you to our office? _____
 Primary care physician's name/phone number _____
 Date of last health exam _____ Date of last eye exam _____
 Current Medications (including prescriptions, over the counter, eye drops, and vitamins) _____

Allergies to medications ___ No ___ Yes _____

Please X if you or a family member have been diagnosed with any of the following:

- | | | | |
|-------------------|---------------------|----------------------|---------------------|
| Allergies | ___ Self ___ Family | Eczema/Rashes | ___ Self ___ Family |
| Arthritis | ___ Self ___ Family | Fatigue | ___ Self ___ Family |
| Blood lymph | ___ Self ___ Family | Fevers | ___ Self ___ Family |
| Bronchitis | ___ Self ___ Family | Genitourinary | ___ Self ___ Family |
| Cancer | ___ Self ___ Family | High blood pressure | ___ Self ___ Family |
| Cholesterol | ___ Self ___ Family | Integumentary (skin) | ___ Self ___ Family |
| Diabetes | ___ Self ___ Family | Kidney | ___ Self ___ Family |
| Digestive | ___ Self ___ Family | Muscle/Bone | ___ Self ___ Family |
| Ears/Nose/Throat | ___ Self ___ Family | Neurological | ___ Self ___ Family |
| Endocrine | ___ Self ___ Family | Psychological | ___ Self ___ Family |
| Throat infections | ___ Self ___ Family | Sinus | ___ Self ___ Family |
| Thyroid | ___ Self ___ Family | Other | _____ |

Print Name _____

Signature _____ **Date** _____

We now offer a digital retinal imaging system that takes images of the retina (the back of the eye.) This highly sophisticated computerized instrument allows the doctor to provide you a more thorough medical analysis of your eye. This procedure assists the doctor in the early detection of many disorders, including glaucoma, diabetic retinopathy, macular degeneration, retinal detachments, and other vision threatening conditions. The images will be stored in the computer and compared with images from future exams. This allows the doctor to observe even the smallest amount of change from the previous procedure.

The doctor strongly recommends that all patients have this procedure performed. It is especially important for people who have:

- Diabetes or family history of:
- High blood pressure
- High cholesterol
- frequent headaches
- Onset of seeing spots or flashes of light
- Glaucoma or a glaucoma suspect
- reached the age of 50

There is an additional charge of **\$37 .00**

-Please check the appropriate box below and sign at the bottom. -

I Do want the procedure performed

I Do not want the procedure

Ask doctor about procedure

Please make sure we have your most current medical and vision insurance information on file. If you are using medical and/or vision insurance coverage for today's visit, please be aware that this is a contract between you and your insurance company, not Lesslie Vision Care. We are happy to file a claim to your insurance company on your behalf, however this is not a guarantee of payment. You/Guardian are responsible for any balances left unpaid.

I have read and understand the above paragraph

ACKNOWLEDGMENT OF RECEIPT

I acknowledge that I have been informed of HIPAA (Health Insurance Portability and Accountability Act of 1996) and have been offered a copy of the privacy policy by the Lesslie Vision Care staff. **DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?**

Name _____ Relationship _____

I understand

I would like a copy

Signature _____ Date _____

Lesslie Vision Care

Contact Lens Fitting Policy & Replenishment Program

The contact lens fitting fee covers the fitting or refitting and evaluation of your contact lenses. Also covered in this fee are any necessary follow up visits to ensure proper fit, vision, and comfort of contact lenses. **All covered follow up visits must be within 90 days of the original contact lens exam. Any necessary contact lens follow ups after 90 days will be charged an office visit for each visit.**

We will not release the contact lens prescription until all follow ups are completed. Contact lenses are medical devices that can cause complications. Even if your vision and the comfort of the contact lenses are good, a microscopic exam of the eye is necessary to ensure that the eye is getting enough oxygen and that the lenses are performing properly. Contact lenses must be worn for at least 2 hours before the follow up visit to ensure proper fitting.

I have received a copy of the contact lens fitting policy.

Signature _____ Date _____