Jennifer M. Lesslie, OD
1370 Remount Rd. Ste. B • N. Charleston, SC 29406 • 843-747-7663

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
_____

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

Secondary 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 **$45.00**

-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 _____