Welcome To Our Office Michael F. Lett, M.D. Today's Date _____

PATIENT INFORMATION (Please Print)

Patient Name _____ Date of Birth ____/____/____ Age _____

Social Security Number _____-_____-_____ (circle): Male/Female

Mailing Address _____
Street *City, State* *Zip*

Primary Phone # (____) _____ *Home/Cell/Work* Alternate Phone # (____) _____ *H/C/W*

Parents/Guardians (if minor) _____

Emergency Contact: Name_____Relationship:_____Phone # (___) _____

Email address _____ Primary Language_____

Marital Status (circle) *Married Single Widowed Divorced Separated* Spouse's name_____

Race (circle) *Asian Black/African American Hispanic White Other (_____)*

Employed (circle): Occupation _____ *Employed / Unemployed / Retired / Disabled / Student*

Employer/School Name _____ Work Phone # (___) _____

PRIMARY CARE PHYSICIAN_____ Referred by_____

Pharmacy Name/Location _____ Phone (___) _____

INSURANCE INFORMATION

MEDICAL
Insurance Carrier_____

VISION
Insurance Carrier_____

Secondary Insurance_____

INSURANCE POLICYHOLDER and/or RESPONSIBLE PARTY: (If other than the patient)

Name _____ Relationship to Patient _____

Address: _____

Home Phone (____) _____ Work Phone (____) _____

Responsible Party SS# _____ Date of Birth _____

Employer Name _____

PATIENT SIGNATURE_____ **Date** _____
Parent/Guardian (if patient is a minor)

Michael F. Lett, MD **Confidential Patient History**

Name:_____ DOB:_____ Date:_____

EYE HISTORY

Last eye exam _____

Currently wearing: Glasses Yes No

Contacts Yes No

Contact Lens Type/Brand_____

Circle: Daily/Weekly/Monthly/Yearly/Hard lenses

Have you or a family member experienced, or been treated for, any of the following?

Please circle	PATIENT		FAMILY
Glaucoma	Yes	No	Family
Cataracts	Yes	No	Family
Diabetes	Yes	No	Family
Dry Eye	Yes	No	Family
Eye Injury	Yes	No	Family
LASIK or RK	Yes	No	Family
Lazy Eye/Crossed Eyes	Yes	No	Family
Macular Disease	Yes	No	Family
Retinal Detachment	Yes	No	Family
Retinal Disease	Yes	No	Family

Are you currently or have you experienced any of the following? Please circle all that apply.

Blurry vision	near/distance/both
Burning/Itching	
Discharge/Infection (Pink eye)	
Double vision	
Dryness	
Excess Tearing/Watering	
Eye Pain/Soreness	
Flashes of light/Halos	
Floaters/Veils/Blind Spots	
Headache/Migraine	
Light Sensitivity	
Redness	
Sandy or Gritty feeling	

SOCIAL HISTORY

Current tobacco use	Yes	No	in the past
Current Alcohol use	Yes	No	in the past

MEDICAL HISTORY

Allergies to medications or materials? Yes No

Please list_____

_____

_____

Have you or a family member experienced, or been treated for, any of the following?

Please circle	PATIENT		FAMILY
AIDS/HIV	Yes	No	Family
Allergies	Yes	No	Family
Arthritis: Rheumatoid/Osteo	Yes	No	Family
Asthma or Bronchitis	Yes	No	Family
Blood/Lymph disorder	Yes	No	Family
Cancer	Yes	No	Family
Cardiac Defibrillator/Pacemaker	Yes	No	Family
COPD	Yes	No	Family
Depression	Yes	No	Family
Diabetes: Type I/Type II/Pre	Yes	No	Family
onset_____ Treament: Diet/Oral Meds/Insulin			
Ear, Nose, Throat Conditions	Yes	No	Family
Fainting Spells	Yes	No	Family
Gastrointestinal Conditions	Yes	No	Family
Hay Fever	Yes	No	Family
Headaches/Migraines	Yes	No	Family
Heart Disease	Yes	No	Family
Hepatitis	Yes	No	Family
High Blood Pressure	Yes	No	Family
High Cholesterol	Yes	No	Family
Kidney Disease	Yes	No	Family
Lupus	Yes	No	Family
Neurological Conditions	Yes	No	Family
Psychiatric Disorder	Yes	No	Family
Seizures	Yes	No	Family
Skin Conditions/Rosacea/Eczema	Yes	No	Family
Stroke	Yes	No	Family
Thyroid Disorder: Low/High	Yes	No	Family

Current Medications and Dosage

(include prescriptions and over the counter)

_____

_____

_____

_____

Michael F. Lett, M.D.,P.C
Financial Policies & Privacy Practices

Patient Name_____ Date of Birth_____

FINANCIAL AGREEMENT All payments and past due balances are due and payable at the time of service. Insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. **I understand that it is my responsibility to pay any co-pay, deductible amount, co-insurance payment, or other balance not paid by my insurance.** The patient is expected to present the insurance card at each visit. We accept cash, check, VISA, Mastercard, or Discover.

FINANCIAL ASSIGNMENT I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished me. I authorize any holder of medical information about me to release to the CMS, its agents, or other insurance carrier, any information needed to determine these benefits or the benefits payable for related services.

REFERRALS & AUTHORIZATIONS It is the responsibility of the patient to obtain all required referrals from the primary care physician. Authorizations will normally be obtained by the office staff, provided the necessary information is available.

RETURNED CHECKS Patients who have checks returned for insufficient finds will expressly authorize their bank account to be electronically debited or bank drafted for the amount of the check plus any applicable fees. The use of the check is the patient's acknowledgement and acceptance of this policy and its terms and conditions. A charge of $25 will be added to the account for each returned check. If the fee is not paid within 10 business days, the charge may be turned over to a collection agency and appropriate fees and interest will apply.

GLASSES ORDERS Glasses orders are filed with your insurance company the same day you order them. Cancellations after 24 hours will result in a $25 service fee.

CONTACT LENS FITTING FEE A contact lens fitting fee will be charged for new contact lens wearers or any current wearers who are refit with a new lens type. Most vision plans do not cover this fee.

PRIVACY PRACTICES I have been advised of the Privacy Practices for this office and authorize Michael F. Lett, M.D., P.C. to release all information necessary for my treatment, payment or health care operations. This includes the sharing of information with other physicians and/or pharmacies. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. Copies of the Privacy Practices are posted in the waiting area and are available upon request.

Other persons who may receive my information_____

I may be contacted by mail or phone ____ Yes ____ No

A message may be left for me ____ Yes ____ No ____ Not Applicable

Patient Signature _____ Date_____
Parent/Guardian (if patient is a minor)