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

PATIENT INFORMATION (Please Print)

Patient Name _____ Age _____ Birthdate _____ Sex _____

Address _____
Street *City, State* *Zip*

Social Security Number _____

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

Which phone number is the best for us to use? *(please circle)* Home Work Cell

If patient is a minor, parents/guardians are _____

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

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

Employed: Y/N Occupation _____ Retired: Y/N Student: Y/N

Employer/School Name _____ Work Phone(___) _____

Primary Care Physician _____ Referred by _____

Pharmacy Name/Location _____ Phone (___) _____

INSURANCE INFORMATION (Please present insurance card)

MEDICAL
Insurance Carrier_____

VISION
Insurance Carrier_____

Secondary Insurance_____

Insurance Holder and/or Responsible Party (If other than the patient, please complete)

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, M.D.

Patient Health History

Patient Name _____ DOB _____ Age _____ Date_____

Please provide the following medical information to the best of your ability.

What are your concerns for today's visit?	List any **Allergies** to medications or materials

Eye History

Glasses ☐ Yes ☐ No Contact Lenses ☐ Yes ☐ No Type/Brand_____

Eye Surgeries (& date)_____ Eye Injuries (& date)_____

Medical History

1) Please check the "Yes" or "No" box to indicate whether you, or a family member, have any of the following illnesses:
if "Yes", please explain and/or list the affected family member.

	Yourself		Family		
	Yes	No	Yes	No	
Glaucoma	☐	☐	☐	☐	_____
Diabetes	☐	☐	☐	☐	_____
Cataracts	☐	☐	☐	☐	_____
Macular Degeneration	☐	☐	☐	☐	_____
Heart Disease	☐	☐	☐	☐	_____
Hypertension- High Blood Pressure	☐	☐	☐	☐	_____
Cancer	☐	☐	☐	☐	_____
Rheumatoid/Osteoarthritis	☐	☐	☐	☐	_____
Thyroid Problems	☐	☐	☐	☐	_____
Allergies	☐	☐	☐	☐	_____

Please list any other major health issues_____

_____

_____

_____

2) Please list any major **surgeries** you have had in the last **5** years, including the date:

_____

_____

_____

3) Please list any **medications** you take currently, including amounts & times per day.
(include aspirin, vitamins, and any over the counter medicines):

_____

_____

_____

_____

_____

_____

Social History:

	Yes	No	Please note number of packs per day
Do you smoke now?	☐	☐	_____
Did you smoke previously?	☐	☐	_____

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)