WELCOME TO THE OFFICE OF
DR. MATTHEW J. LENTSCH, *BOARD CERTIFIED OPTOMETRIC PHYSICIAN*

PATIENT INFORMATION

DATE _____

PATIENT NAME: LAST _____ FIRST _____ MI _____

SOCIAL SECURITY #: _____ BIRTH DATE: _____ AGE: _____

SEX: _____ MALE _____ FEMALE EMPLOYER/OCCUPATION: _____

HOME PHONE: _____ CELL PHONE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

E-MAIL ADDRESS: _____

MAY WE CONTACT YOU BY EMAIL FOR APPOINTMENT REMINDERS? ☐ YES ☐ NO TEXT? ☐ YES ☐ NO

HOW DID YOU HEAR ABOUT LENTSCH EYE CARE? ___ SAW SIGN ___ REFERRAL ___ WEB SITE ___OTHER _____

IF REFERRAL, WHOM MAY WE THANK? _____

GUARDIAN/SPOUSE NAME: (PERSON RESPONSIBLE FOR THIS ACCOUNT IF PATIENT IS A MINOR/INSURANCE POLICY HOLDER)

RELATIONSHIP TO PATIENT: _____

LAST _____ FIRST _____ MI _____

SOCIAL SECURITY #: _____

EMPLOYER/SCHOOL: _____

BIRTH DATE: _____ AGE: _____ SEX: _____ MALE _____ FEMALE

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

E-MAIL ADDRESS: _____

PERSONAL SOCIAL HISTORY

DO YOU HAVE A HISTORY OF TOBACCO, ALCOHOL OR NARCOTICS USE? ___ NO ___ YES
DO YOU HAVE A HISTORY OF STD OR BLOOD TRANSFUSIONS? ___NO ___YES

TOBACCO USE (CHECK ALL THAT APPLY)

☐ FORMER SMOKER ☐CURRENT EVERYDAY SMOKER ☐CURRENT SOME DAY SMOKER ☐ HEAVY SMOKER ☐ LIGHT SMOKER
☐ SMOKELESS TOBACCO USER

STOPPED SMOKING (CHECK ALL THAT APPLY)

☐ WITHIN LAST YEAR ☐ 1-2 YEARS AGO ☐ 3-4 YEARS AGO ☐ 4-5 YEARS AGO ☐ 5+ YEARS AGO ☐ 10+ YEARS AGO

ALCOHOL USE (CHECK ALL THAT APPLY)

☐ NONE ☐SOCIAL USE ONLY ☐ 1-2 DRINKS DAILY ☐ ABOVE AVERAGE USE ☐ ALCOHOL DEPENDENCE

PERSONAL MEDICAL HISTORY (CHECK THOSE THAT APPLY TO YOU :)

___ DIABETES	___ MIGRAINE HEADACHES	___ HIGH BLOOD PRESSURE	___ DEPRESSION
___ LUPUS	___ MULTIPLE SCLEROSIS	___ ASTHMA/EMPHYSEMA	___ TUBERCULOSIS
___ THYROID DISEASE	___ SARCOIDOSIS	___ STROKE	___ HIV/AIDS
___ RHEUMATOID ARTHRITIS	___ HEART DISEASE	___ CANCER TYPE_____	___ LUNG DISEASE
___ GIANT CELL ARTERITIS	___ KIDNEY DISEASE	___ ANEMIA	

PLEASE LIST ALL MEDICAL CONDITIONS NOT LISTED ABOVE: _____

_____

_____

Welcome to the office of
Dr. Matthew J. Lentsch, *Board certified optometric physician*

Medications

List any medications you are currently taking, including eye drops:

_____

_____

_____

_____

_____

_____

Allergies

List your allergies to medications and other substances:

_____

_____

_____

_____

Pharmacy Name_____

Phone (_____)_____

Eye Health History

Date of your last eye exam: _____

Do you wear glasses? ____ No ____ Yes **If yes, how old is your present pair?** _____

Do you wear contact lenses? ____ No ____ Yes **If yes, do you wear:** ____ Soft ____ Gas permeable ____ Hard

Have you had previous eye disease, eye injury or eye surgery? ____ No ____ Yes If yes, explain:

_____

_____

Check if you have been diagnosed with:

___ Glaucoma ___ Amblyopia ___ Cataracts
___ Retina Detachment ___ Macular degeneration ___ Strabismus
___ Other _____

Check if you have family history of:

___ Glaucoma ___ Macular Degeneration ___ Strabismus
___ Vision Loss

Personal Medical History

Physician's Name _____ Date of last visit _____

Are you diabetic? ☐ Yes ☐ No If Yes, How long have you been diabetic? _____

What is your A1C? _____

What is the name and address of the doctor that follows your diabetes?

_____

_____

When was your last diabetic exam? _____

Dilation

Our doctor strongly recommends that all patients receive a dilated eye examination every year. A dilated eye examination allows the doctor to evaluate the health of the retina and the inside of the eye. This aids the doctor in determining diseases such as macular degeneration, glaucoma, diabetic retinopathy, retinal holes and tears, cataracts and tumors of the eyes. Please select one of the following boxes below.

☐ I **Agree** to have my eyes dilated today and understand the importance of an annual dilated exam.

☐ I **Do Not** wish to have my eyes dilated today. And, I release Dr. Lentsch from any liabilities related to the failure to treat or diagnose any eye conditions due to the lack of diagnostic information, which could have been obtained by these tests.

Welcome to the office of
Dr. Matthew J. Lentsch, *Board certified optometric physician*

Vision Care Insurance vs. Medical Insurance

We often have patients that have both vision insurance (IE: VSP or Eyemed) and medical insurance (IE: BCBS, Aetna or Medicare). They are very different in terms of the services they cover, and it's important for our patients to understand these differences.

Vision Insurance is designed mainly to cover determining a prescription for glasses, to help pay for glasses or contact lenses, and to cover a yearly routine evaluation of the health of the eyes in a healthy patient that has no particular problems or symptoms. It is not equipped to deal with and does not usually cover medical conditions, injuries, and/or treatments.

Medical insurance is designed to cover you when you have a medical problem, including one that affects your eyes. Medical insurance does not cover routine services or examinations for glasses, or routine vision problems such as nearsightedness, farsightedness and astigmatism. Those are only covered by your **vision insurance**.

When a medical diagnosis or medical condition is present that affects your eyes, such as high blood pressure, high cholesterol or diabetes, or you have an eye disease or problem such as an infection (pink eye), dry eyes, allergies or cataracts, we must file the claim with your **medical insurance**, and the co-pays and deductibles for that insurance will apply. Your vision plan does not cover these kind of problems. Our office does not make these rules, they are made by the insurance companies, and we must comply with them.

There is often no way to know prior to your examination which type of insurance will be the right one to file your claim with. We make every effort to join as many insurance panels, both medical and vision, as we can for your convenience. If we are on your insurance company's panel we will file those claims for you. In the event that we do not accept your medical or vision insurance we will provide you with an itemized receipt so that you may file a claim for reimbursement with your insurance company yourself. If you have any questions, please let us know.

I understand the information I've just read about the difference between vision and medical insurance. I authorize Dr. Lentsch to file my claim with the appropriate insurance based on the reason for my visit and the results of my examination.

Signature:_____ **Date:**_____
(Patient/Parent or Guardian if Minor)

Notice of Non-Covered Services

All Comprehensive Eye Exams performed by Dr. Lentsch include a Refraction. Refraction is the procedure used to determine if you have a need for glasses, or if you have a change in prescription. Not all insurances (Excluding Vision Plans) consider a refraction a medical necessity and therefore will not pay. In the event your insurance does not cover the Refraction, you will be responsible for payment.

☐ I understand that a refraction will be performed and if my insurance does not cover it, I am responsible for payment.

Signature:_____ **Date:**_____
(Patient/Parent or Guardian if Minor)