Welcome to the office of
Dr. Matthew J. Lentsch, *Board Certified Optometric Physician*

Patient Information

Today's Date _____

Patient name: Last _____ First _____ MI __

Social security #: _____ **Date of Birth:** _____ **Age:** _____

Gender:_____ **Employer/Occupation:** _____

Home phone: _____ **Cell phone:** _____

Address: _____**City:** _____ **State:** _____ **Zip:** _____

E-mail address: _____

Emergency Contact: _____ **Relationship to Patient:** _____

Emergency Contact Phone Number: _____

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? _____

Insurance Policy Holder /Guardian (Person responsible for this account if patient is a minor)

Relationship to patient: _____

Last _____ **First** _____ **MI** _____

Social security #: _____

Birth date: _____

Phone Number: _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Personal Social history

Do you have a history of narcotics use? ☐ **Yes** ☐ **No**
Do you have a history of STD? ☐ **Yes** ☐ **No**
Do you have a history of blood transfusions? ☐ **Yes** ☐ **No**

TOBACCO USE (Check all that apply)

☐ **Never Smoked** ☐**Current Everyday Smoker** ☐**Current Some Day Smoker** ☐ **Heavy Smoker**
☐ **Light Smoker** ☐ **Smokeless Tobacco User** ☐ **Former Smoker**

STOPPED SMOKING

☐ **Within last year** ☐ **1-2 years ago** ☐ **3-4 years ago** ☐ **4-5 years ago** ☐ **5+ years ago** ☐ **10+ years ago**

ALCOHOL USE

☐ **None** ☐**Social use only** ☐ **1-2 drinks daily** ☐ **Above average use** ☐ **Alcohol dependence**

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Personal Medical History

____ Diabetes ____ Lupus ____ Thyroid disease ____ Rheumatoid arthritis ____ Giant cell arteritis ____ ADHD/ADD	____ Migraine headaches ____ Multiple Sclerosis ____ Sarcoidosis ____ Heart disease ____ Kidney disease ____ High Cholesterol	____ High blood pressure ____ Asthma/emphysema ____ Stroke ____ Cancer (Cancer Type_____) ____ Intellectual Disability	____ Depression ____ Tuberculosis ____ HIV/AIDS ____ Lung disease ____ Sleep Apnea/CPAP ____ Sjogren's Syndrome

Please list all medical conditions not listed above: _____

_____

Primary Physician _____If you are diabetic, how long have you been diabetic? _____

What is your most recent A1C? _____

What is the name of the doctor that follows your diabetes (if different from above)? _____

When was your last diabetic exam with the above physician? _____ Permission to release records to physicians ☐Yes ☐No

Signature: _____ Date: _____

Medications & Eye Drops

If list is available, see front desk to scan & make a copy

_____

_____

_____

_____

_____

_____

Allergies

List your allergies to medications and other substances:

_____

_____

_____

_____

_____

Eye Health History

Date of your last eye exam: _____

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

Do you wear contact lenses? ☐ **Yes** ☐ **No** **If yes, do you wear:** _____ Soft _____ Hard/Gas Permeable

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

_____

_____

Check if you have been diagnosed with:

____ Glaucoma ____ Amblyopia ____ Cataracts
____ Retinal Detachment ____ Macular degeneration ____ Strabismus
____ Other _____

Check if you have family history of:

____ Glaucoma ____ Macular Degeneration ____ Strabismus ____ Vision Loss

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Vision Care Insurance vs. Medical Insurance

We often have patients that have both Vision Insurance (IE: VSP, EyeMed, Aetna Vision, Spectera, Humana Vision, Etc.) and Medical Insurance (IE: Blue Cross Blue Shield, Aetna, Medicare, United Health Care, Etc.). They are very different in terms of the services they cover, and it is important for our patients to understand these differences.

Vision Insurance is designed mainly to cover the process in determining a prescription for glasses/contacts and to aid in the cost of materials (frame and lens or contacts). Vision insurance typically covers a yearly routine evaluation of the health of the eyes which includes dilation and any vision complications such as nearsightedness, farsightedness and astigmatism. It does not usually cover medical conditions and emergencies such as eye infections, foreign body, injuries, and/or treatments.

Medical Insurance is designed to cover when there is a medical problem present (IE: eye infections, foreign body, injuries, and/or treatments) and/or the need for additional testing in eye diseases such as Glaucoma, Macular Degeneration, Diabetic Retinopathy, etc. Medical insurances typically do not cover routine eye examinations or glasses/contacts. There are rare cases where some, **NOT ALL**, medical insurances will cover one routine eye exam per year. When a claim is filed with any insurance, patients are responsible for any copays, coinsurances and/or deductibles that apply, which are determined by your insurance provider.

We make every effort to join as many insurance plans, both medical and vision, as we can for your convenience. If we are a provider for your particular insurance company, we 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.

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

Date:_____

Notice of Non-Covered Services (Medical Insurance)

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 consider a refraction a medical necessity and therefore will not pay (such as traditional Medicare, Medicare Replacement Plans, and medical insurances like Blue Cross Blue Shield, Florida Blue, United Health Care, etc) . In the event your insurance does not cover the Refraction, you will be responsible for payment. Vision insurance (such as VSP, Eyemed, Aetna Vision, Spectera, Humana Vision, etc.) cover the refraction and do not charge an extra copay.

☐ I understand that a refraction will be performed and I am responsible for payment of **$30.00,** on the day this service is rendered. In the event that insurance does pay the refraction, I will be refunded for $30.00.

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

Date:_____