Welcome to the Practice of **Dr. David Lelonek,** *Jack Doby® Optometrist*

(Please make sure to especially fill out the BOLDED information)

Last Name, First Name: _____ Gender:_____ **Birth Date:** _____
Address: _____**City:** _____State: ____**Zip code:** _____
Home Phone: _____ Work Phone: _____ **Cell Phone:** _____
Age: _____ **Patient's Occupation:** _____**Email:** _____
Emergency Contact: (Name/Number): _____ **Relationship:**_____
Last Exam Date: _____ Dilated? _____ **What is your reason for visit:** _____
Marital Status: _____ Spouses Name: _____ **Are you feeling well today?:**_____

Do you have any of these conditions? (*Please circle all that apply*):

Blurred Vision Double Vision Floaters Loss of Vision Diabetes Hypertension Watery / Teary Eyes
Eye Infection Glaucoma Eye Injury Eye Surgery Cataracts Sensitivity to Light Retinal Problems
Crossed Eyes Headaches Retinal Disease Seeing Flashes Seeing Halos Seeing Spots Macular Degeneration
Retinal Detachment Coronavirus/COVID-19 Smoker – if so, how much and/or how often: _____
Other Health Problems: _____

Allergies: _____

Current Medication: _____

Any CLOSE/BLOOD RELATIVES had/have any of the following health issues *(Please circle all that apply):*

COVID-19 High Blood Pressure Diabetes Glaucoma Macular Degeneration Retinal Detachment Eye Diseases/Blindness

Retinal Scan

Please choose "Yes", "No" or "Schedule me for another day", if you would like the **Optomap Retinal Exam** today *(this test is Strongly Recommended by our Doctors).* Please read the laminated sheet or inquire with the Doctor, if you have any questions. There is an **additional $50 fee** for this exam, but it may be fully covered with some health plans.

☐ **Yes** Please Schedule me for a later day: _____ ☐ **No**

Insurance Information

Primary Health Insurance Name: _____ **Insurance ID Number:** _____ **Insured's D.O.B.**_____

Name of Primary Card Holder: _____ **Last 4 of Primary's SSN:** _____ **Relation to Patient:** _____

Secondary Health Insurance Name: _____Insurance ID Number: _____

I certify that I have insurance coverage with the above-named carrier(s) and assign directly to **Dr. Lelonek** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Dr.Lelonek may use my health care information and may disclose such information to the above-named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits of the benefits payable for related services. This consent will end when my current treatment is completed or one year from the date signed below.

Medicare/Medigap/Insurance Authorization: I request that payment of authorized Medicare/Medigap/Insurance benefits are made either to me or on my behalf to Dr. Lelonek for services furnished to me by that provider. To the extent permitted by law, I authorize any holder of medical or other information about me to be releases to the Center for Medicare and Medicaid services, my Medigap insurer, my Insurance company and their agents any information needed to determine these benefits or benefits for related services.

Patient/Parent's or Guardians' Signature: _____ **Date:** _____

HIPAA Information: I authorize the use or disclosure of my individual identifiable health information to the minimal extent necessary with Jack Doby® Optical, or their agents (this may include my name, address, telephone number, email address and appointment history). I understand that this information being disclosed will no longer be protected by federal privacy regulations. It may be used for appointment scheduling, recalls, product information and mailings. I understand that this authorization is voluntary and this if I refuse to sign, it will not affect my ability to obtain treatment, receive payment or eligibility for benefits unless allowed by law. I can revoke this authorization at any time by notifying this office.

Patient/Parent's or Guardians' Signature: _____ **Date:** _____