WELCOME TO DR. JOHN H. LEE AND ASSOCIATES

Name_____ Today's Date_____
Address_____ Sex: M F Marital Status _____
City/State/Zip_____ Date of Birth _____/_____/_____ Age_____
Phone #s Home _____ Social Security Number_____
Work_____ Employer _____
Cell _____ Occupation_____
Primary Care Physician _____ Email Address_____
Primary Care Physician Phone #_____ Date Last Seen (PCP)_____
Previous Eye Doctor _____ Date Last Seen _____

Have you ever worn eye glasses? Y N Do you still wear them? Y N
*Uses for glasses:(please circle) work, computer, reading, driving, weekend, sports, sun, safety, back up to contact lenses

*Interested in contact lenses: Y N Have you ever worn contact lenses? Y N Do you still wear them? Y N
If yes, what type of contacts?_____ Replacement Schedule_____ Cleaning System_____

Are you experiencing any of the following issues? (Circle Y for YES and N for NO)

Y	N	No Problems - Routine Visit	Y	N	Foreign Body Sensation
Y	N	Blurred Vision - Distance	Y	N	Pain In/ Around Eyes
Y	N	Blurred Vision - Near	Y	N	Seeing Spots or Floaters
Y	N	Double Vision	Y	N	Seeing Light Flashes
Y	N	Difficulty Seeing Computer	Y	N	Increased Light Sensitivity
Y	N	Difficulty Driving at Night	Y	N	Dry Eyes
Y	N	Eyes Itch or Burn or both	Y	N	Eye Injury (Right or Left)
Y	N	Eyes Water or Tear	Y	N	Headaches - How Often?_____
Y	N	Discharge from Eyes	Y	N	Other Problems:_____

To ensure a more thorough eye health exam, please tell us your general health and family history as these may have an effect on your vision and ocular health. All information is kept strictly confidential. (Circle Y for YES and N for NO)

Yourself		Family			Yourself		Family		
Y	N	Y	N	High Blood Pressure	Y	N			Seasonal Allergies
Y	N	Y	N	Diabetes	Y	N	Y	N	Blindness
Y	N	Y	N	Sarcoidosis	Y	N	Y	N	Glaucoma
Y	N	Y	N	Sickle Cell Anemia	Y	N	Y	N	Cataracts
Y	N	Y	N	Thyroid Disease	Y	N	Y	N	Retinal Disorders
Y	N	Y	N	Auto Immune Disorder_____	Y	N	Y	N	Crossed/ Lazy Eyes
Y	N	Y	N	Multiple Sclerosis	Y	N			Eye Surgery/ Which Eye? _____
Y	N	Y	N	Cancer (type) _____	Y	N			Severe Eye Injury/ Which Eye?_____
Y	N	Y	N	Circulation Problems	Y	N			Are you pregnant?
Y	N	Y	N	Respiratory Problems	Y	N			AIDS/ HIV Positive
Y	N	Y	N	Chemical Dependency	Y	N			Infectious Disease(List)_____
Y	N	Y	N	Tobacco Use	Y	N	Y	N	Other_____

Please list all medication either prescribed or over the counter medication that you currently or should be taking:

_____

_____

_____

_____

Are you allergic to any medications or eye drops (List)_____
Is there anything you would like to discuss with the Doctor during your visit?_____

_____

Whom may we thank for referring you to us?_____

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Patient Name (If patient is under 18, the name of the responsible party) _____

I acknowledge that I will be a self-paid patient today. That means that I will be paying my balance today in full at the time of service. I will not be sending in a claim to an insurance company of which this practice is already a provider.

_____ _____

Signature of patient or responsible party Date

INSURANCE INFORMATION AND RELEASE OF INFORMATION

In the event that your insurance does not pay for the services provided in our office, you will be responsible for any unpaid balances. Verification of vision coverage does not guarantee insurance company payment. Payment is based on actual coverage and policy determination upon reciept of the claim for the date of service. It is also your responsibility to know and understand any deductible or co-insurance payments your plan has that you will be responsible to pay. Please provide the following information that is necessary so that we are able to process your claim.

PATIENT NAME	PATIENT DATE OF BIRTH / /	PATIENT SOC SEC #
POLICY HOLDER NAME	POLICY HOLDER DATE OF BIRTH / /	HOLDER SOC SEC #
POLICY HOLDER'S EMPLOYER		Patient Relationship to the Policy Holder (please circle) CHILD SPOUSE SELF
VISION PLAN NAME	VISION PLAN ID NUMBER	GROUP NUMBER /
MEDICAL INSURANCE NAME	MEDICAL INS ID NUMBER	GROUP NUMBER /
SECONDARY MEDICAL INSURANCE NAME	SECONDARY MED INS ID NO.	GROUP NUMBER

I, _____, have read the above, and understand that I am responsible
(PATIENT OR PERSON RESPONSIBLE FOR THE PATIENT'S BILL)
for any balance that my insurance company does not pay. I am also acknowledging that all of the information I have provided is accurate and correct. I understand that failure to provide the most accurate and true information will result in my claim being denied. I am also acknowledging that I agree to release all necessary medical and demographic information from my records at this office to my insurance company.

_____ / /

SIGNATURE OF THE PATIENT OR THE PERSON RESPONSIBLE FOR THE PATIENT'S BILL DATE

OFFICE USE ONLY

AUTHORIZATION NUMBER:_____ _____ _____

ROUTINE EXAMINATION CL FITTING CONTACT LENSES

ELIGIBILITY VERIFIED (PLEASE CIRCLE VIA FAX VIA INTERNET VIA TELEPHONE _____

NAME OF VERIFIER

ELIG FOR EXAM: Y N ELIG FOR CL FITTING: Y N ELIG FOR CONTACT LENS ALLOWANCE: Y N

CO-PAY_____ CO-PAY_____ AMOUNT OF ALLOWANCE_____