Welcome to the Practice of **Dr. David Lelonek,** *Independent J.C. Penney Optometrist*

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**: _____
Marital Status: _____ Spouses Name: _____
Last Exam Date: _____ Dilated? _____ **What is your reason for this visit?** _____

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

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

Other health Problems: _____

Allergies: _____

Current Medications: _____

_____

Any blood Relatives had/have any of the following? (*Please circle all that apply*)

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

Retinal Scan:

Please choose "Yes", "No", or "Schedule me for a later day", in reference to the Optomap Retinal Exam (this test is Strongly Recommended by our Doctors). Please read the laminated sheet or inquire with the Doctor, if you have any questions. Also there is an additional $45 fee for this exam although it may be covered with some health plans.

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

Insurance Information:

Primary Health Insurance Name: _____Insurance ID Number: _____

Primary Card Holder: _____Relation to Patient: _____

Secondary Health Insurance Name: _____Insurance ID Number: _____

I certify that I have insurance coverage with_____ 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 one year after my last day of treatment is completed or one year from the date signed below.

Medicare/Medigap Authorization: I request that payment of authorized Medicare benefits and, if applicable, Medigap 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 released to the Center for Medicare and Medicaid services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

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