Lesslie Vision Care
Jennifer M. Lesslie, OD
Betsy W. Fraser, OD
1370 Rmount Rd. Ste. B
N. Charleston, SC 29406

PLEASE FILL OUT FORM COMPLETELY

Last:___________________________ First:___________________________ MI:____ Male/Female

Address:______________________________ City:__________________ State:_____ Zip Code:__________

Home Phone:________________ Work Phone:_________________ Cell Phone:__________________

Email Address:_____________________________ SSN__________________ Date of Birth____________

Height:________ Weight:_______ Marital Status: Married/Single/Widowed/Divorced/Seperated

Employer_________________________________ Occupation_____________________________________

Spouse/Guardian's Name_____________________ Spouse/Guardian's Employer______________________

Vision Insurance:_______________________________
Policy Holder's Name:___________________________
Policy Holder's Date of Birth:_____________________
Policy Holder's SSN:____________________________

Primary Medical Insurance:_________________
Policy Holder's Name:______________________
Policy Holder's Date of Birth:_______________
Policy Holder's SSN:______________________

Secondary Medical Insurance:_______________
Policy Holder's Name:______________________
Policy Holder's Date of Birth:_______________
Policy Holder's SSN:______________________

Who may we thank for referring you to our office? ____

Primary care physician's name/phone number____
Date of last health exam_____________________ Date of last eye exam_____________________________
Current Medications (including perscriptions, over the counter, eye drops, and vitamins)
____

Allergies to medications No/Yes ____

Please circle if you or a family member have been diagnosed with any of the following:

Allergies	Self Family	Eczema/Rashes	Self Family
Arthritis	Self Family	Fatigue	Self Family
Blood lymph	Self Family	Fevers	Self Family
Bronchiti	Self Family	Genitourinary	Self Family
Cancer	Self Family	High blood pressure	Self Family
Cholesterol	Self Family	Integumentary (skin)	Self Family
Daibetes	Self Family	Kidney	Self Family
Digestive	Self Family	Muscle/Bone	Self Family
Ears/Nose/Throat	Self Family	Neurological	Self Family
Endocrine	Self Family	Psychological	Self Family
Throat infections	Self Family	Sinus	Self Family
Thyroid	Self Family	Other ___________________________________	

Print Name:____

Signature____Date_____________________