

WINK OPTOMETRY

Name: _____ DOB: _____ Age: _____ Last 4 SSN: _____ Occupation: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Home# _____ Work# _____ Cell# _____ Email: _____
 Last Medical Exam: _____ Emergency Contact: _____ Phone # _____
 Insurance: _____ Primary Subscriber: _____ Last 4 SSN: _____ Relationship: _____

OCULAR/SOCIAL/MEDICAL HISTORY

Last eye exam date: _____ Do you wear glasses? Yes No If yes, how old are they? _____
 Do you wear contact lenses? Yes No If yes, what contact lens brand/type are they? _____
 Hx of Eye Surgery? Date? Yes _____ No

PLEASE LIST MEDICATIONS: _____

Allergies to medication? Yes _____ No
 Pregnant/Nursing? Yes No N/A
 Do you use tobacco products? Yes No Drink alcohol? Yes No Recreational Drugs? Yes No
 Have you ever been infected with: COVID Gonorrhea Hepatitis HIV/AIDS Syphilis

Do you have any of the following eye concerns?

- Blurry Vision Eyestrain Severe Sensitivity to Light Frontal Headache Glare/Halos
- Poor Night Vision Double Vision Distorted Vision Eye Trauma/Injury Burning
- Fluctuating Vision Discharge Eye Pain/Soreness Flashes/Floaters Itching
- Tearing/Watering Dry Eye Contact Lens Overwear Corneal Ulcer Uveitis
- Eye Infection Redness

	SELF	FAMILY		SELF	FAMILY		SELF
Macular Degeneration			Brain Tumor			Shingles	
Cataracts			Migraine Headaches			Asthma	
Glaucoma			Diabetes (Type 1/ Type 2)			COPD/Emphysema	
Diabetic Retinopathy			Thyroid Dysfunction			Sleep Apnea	
Keratoconus			Kidney Disease			Epilepsy/Seizure	
Amblyopia			Allergies			Depression	
Strabismus			Anemia			Anxiety	
Retinal Detachment			Rheumatoid Arthritis			Bipolar	
Retinitis Pigmentosa			Lupus			ADD/ADHD	
Color Blindness			Sjogren's Syndrome			Eczema	
Cancer			Multiple Sclerosis			Rosacea	
Hypertension			Crohn's Disease			Psoriasis	
Cholesterol			Ulcerative Colitis			Gout	
Heart Disease			Ankylosing Spondylitis			Developmental Disability	
Stroke			Scleroderma			Other:	

How did you hear about us? _____

Acknowledgement of Receipt of Privacy Notice

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law designated to protect the privacy of your health information. We understand that the information about you and your health is personal, and at WINK OPTOMETRY, we are committed to protecting the privacy of that information. Because of this commitment, we must obtain your special authorization before we may use or disclose your protected health information to any party. This office will only use and disclose necessary personal health information to permit the office to perform its administrative duties, provide eye care services, process vision benefit claims, or mail exam recalls.

 (Patient's Signature or Legal Representative)

 (Date)

PLEASE TURN OVER AND COMPLETE SIDE TWO

DIGITAL OCULAR HEALTH RETINAL EXAM

We are proud to offer the latest in retinal imaging, the Optomap. It is painless, quick, and allows a view into the health of your eyes, **without** affecting vision. This procedure can monitor for retinal complications including macular degeneration, glaucoma, and retinal holes or detachments. It may also detect problems unrelated to the eye that may show early signs in the retina such as hypertension, diabetes, cancer/tumors and autoimmune disorders. The photos will be saved in your file enabling your optometrist to make important comparisons during your annual eye examination. The doctor recommends this for all patients.

The Optomap Retinal Exam:

- ✓ Is as fast as taking a picture.
- ✓ Does not require dilating drops. You **may not** need to be dilated today, potentially avoiding side effects such as blurry vision and light sensitivity.
- ✓ Will be saved in your file enabling your optometrist to make important comparisons during your annual eye exam.
- ✓ Is recommended for all patients.
- ✓ Has a **\$39 copay**.



_____ I understand that the Optomap Retinal Exam will be performed today.

_____ I want to speak to the doctor for more information and understand that declining this procedure may limit the doctor's ability to optimally assess my ocular health.

DILATION CONSENT

Dilation is the enlargement of the pupil diameter, which allows another method for the doctor to observe the internal eye to rule out conditions such as glaucoma, retinal detachments, cataracts, eye tumors, and other sight or life-threatening conditions. We always prefer to have our patients driven after their dilation, as the eye drops cause blurred vision and light sensitivity for about 6 hours. Disposable shaded lenses might be provided to reduce light sensitivity. Please consult the front desk if there are any questions.

_____ YES, I give permission to the doctor to perform dilation today.

_____ NO, I choose not to have dilation done. I understand that an exam of the retina through a dilated pupil is necessary to detect conditions that would otherwise not be observable. These conditions, if undetected, may lead to partial or total vision loss.

_____ I prefer to have dilation done at a later date.

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the eye doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependent during the period of such eye care to third party payers and /or health practitioners. I authorize my insurance company to pay directly to **WINK OPTOMETRY**. I understand that my insurance carrier may not cover some services and products and benefit information does not constitute approval of payment. Deductible and fees not paid by my insurance carrier will be my responsibility. I also understand that there will be no refunds for rendered professional medical services related to eye exams or contact lens fitting or evaluations.

(Patient's Signature or Legal Representative)

(Date)