WINK OPTOMETRY

Name:_____DOB:_____Age: ____ Last 4 SSN:_____ Occupation:_____

Address: _____City:_____State:_____Zip:_____

Home#_____Work#_____Cell#_____Email: _____

Emergency Contact: _____Phone #_____

Last Medical Exam:_____Name of Medical Doctor: _____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 brand/type are they? _____

Medications/Eye Drops:_____

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 exposed to or infected with: □ 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	□ Eye Surgeries _____		

	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

DILATION CONSENT

Dilation is the enlargement of the pupil diameter, which allows the doctor to observe the internal eye more completely 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.

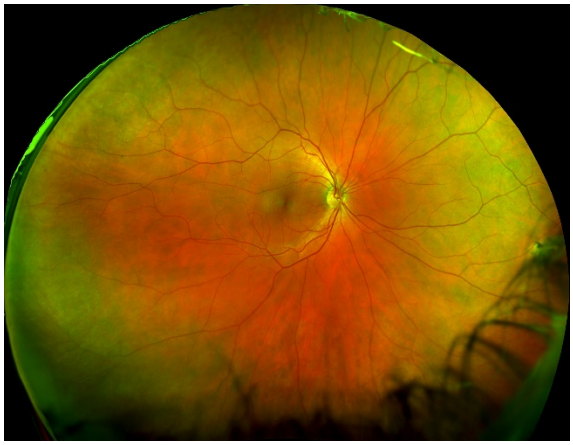
_____YES, I give permission to the doctor to perform dilation today.
_____ NO, I choose not to have dilation done. I understand that an exam of the retina through a dilated pupil is necessary to detect conditions that would otherwise be unobservable. These conditions, if undetected, may lead to partial or total vision loss.
_____I prefer to have dilation done at a later date.

OPTOMAP RETINAL EXAM

We are proud to offer the latest in retinal imaging, the Optomap. It is painless, quick, and allows another method at looking at the health of your eyes. This screening 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.

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)