WINK OPTOMETRY

NAME:_____DOB_____Age: ____ SS#_____ Occupation_____

Address:_____City_____State_____Zip_____

Phone#_____Work#_____Cell#_____Email:_____

Emergency Contact:_____Phone #_____

Last Eye Exam _____Last Medical Exam_____Name of Medical Doctor _____Phone#_____

Insurance:_____Primary Subscriber:_____SS#_____Relationship:_____

FAMILY HEALTH HISTORY

Please check any conditions that apply to your immediate family members:

☐Blindness	☐Glaucoma	☐Heart Disease	☐Thyroid Disease
☐Cataract	☐Macular Degeneration	☐High Blood Pressure	☐Other:_____
☐Crossed Eyes	☐Retinal Detachment	☐Lupus	_____
☐Diabetes	☐Cancer	☐Arthritis	_____

PATIENT'S OCULAR/ MEDICAL HISTORY

Do you have any allergies to medications? _____Yes ____No. If yes, please list_____
List all the medications you are currently taking:_____
List all the major injuries, surgeries, and /or hospitalization you have had:_____
Are you pregnant and/or nursing? ____ Yes ____No
Do you wear glasses? ____ Yes ____No If yes, How old is your current pair of glasses? _____
Do you wear contact lenses? ____ Yes ____No Type of contact lenses: _____

Please check any conditions that you have or have had in the past:

☐Blurred Vision	☐Macular Degeneration	☐Diabetes	☐Arthritis
☐Loss of Vision	☐Glaucoma	☐High Blood Pressure	☐Anemia
☐Double Vision	☐Pain	☐High Cholesterol	☐Anxiety/Depression
☐Crossed Eyes	☐Excessive Tearing	☐Stroke	☐Sinus Congestion
☐Lazy Eye	☐Dryness	☐Headache	☐Asthma
☐Eye Surgery	☐Itching/Burning	☐Migraine	☐Emphysema
☐Cataract	☐Mucus Discharge	☐Seizure	☐Other:_____
☐Retinal Detachment	☐Eye Injuries	☐Thyroid	_____
☐Flashes/Floaters	☐Eye Infection/Redness	☐Cancer	_____

SOCIAL HISTORY

Do you use tobacco products? ____ YES ____NO (If yes) type/ amount/ how long:_____
Do you drink alcohol? ____YES ____NO (If yes) type/ amount/ how long:_____
Do you use recreational drugs? ____YES ____NO (If yes) type/ amount/ how long:_____
Have you ever been exposed to or infected with: _____ Gonorrhea _____Hepatitis _____HIV _____Syphilis

HOW DID YOU HEAR ABOUT US? _____

NOTICE OF PRIVACY

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.**

By signing below, I acknowledge that I have read/receive the copy of the Notice of Privacy Practices for review.

_____ _____

(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.

RETINAL PHOTOGRAPHY

Retinal photography can document and record retinal problems, optic nerve disease, suspicious lesions, macular degeneration, high blood pressure, effects of diabetes, etc. The digital image will also be stored on our computer system. We can provide copies of these photos for your medical specialist if referral is indicated. We encourage all our patients to have this procedure to establish a reference base on your ocular health before any problems develop. Patients with certain conditions such as diabetes, high blood pressure, macular degeneration, migraine headaches, floaters, and high prescriptions are particularly urged to have these photos taken. The customary charge for retinal photography is $80 when documenting a known abnormality. Since we feel that baseline retinal photography can be a great benefit to our patients, our charge will be reduced to **$35**. To receive this discount, the fee is payable at the time of this service. Please indicate your preference by checking the appropriate response and then sign at the bottom of the form.

_____YES, I want the retinal photography.
_____NO, I decline to have the retinal photography at this time.
_____Discuss with the doctor first.

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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 parties 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)