Blink Eyewear and Eyecare New Patient Information

General Information

Today's Date: _____

Patient Name: _____

Preferred Pronoun (optional):_____

Date of Birth: _____

Phone: _____

Email: _____

How did you learn about our office?

_____

Reason for Visit: _____

Date of Last Eye Exam: _____

Previous Provider: _____

Do you currently wear glasses? ____ Yes ____ No

Do you currently wear contacts? ____ Yes ____ No

If so, what kind? _____

Please list any current issues with glasses or contacts:

_____

Have you ever been diagnosed with or treated for:

____ Glaucoma
____ Cataract
____ Macular Degeneration
____ Retinal Hole/Detachment
____ Keratoconus
____ Eye Injury
____ Eye Inflammation
____ Dry Eye
____ Strabismus
____ Amblyopia

Have you ever had any eye surgery? ____ Yes ____ No

Type? Cataract / Lasik / PRK / Other _____

Are you pregnant or nursing? ____ Yes ____ No

Do you smoke? ____ Yes ____ No

Do you drink alcohol? ____ Yes ____ No

Patient Medical Information

Please list all active medications including eye drops, vitamins/supplements, and birth control pills **or list NONE:**

_____

_____

Please list any allergies to medications **or list NONE**:

_____

Have you ever been diagnosed with or treated for:
(circle where applicable)

Constitution:
___ Cancer
___ Developmental Disability

Ear/Nose/Throat:
___ Hearing Loss
___ Dry Mouth

Neurological:
___ Multiple Sclerosis
___ Migraine / Epilepsy
___ Autism Spectrum Disorder

Psychological:
___ Depression / Anxiety
___ Attention Deficit

Cardiovascular:
___ High Blood Pressure
___ Heart / Vascular Disease

Respiratory:
___ Asthma / COPD
___ Sleep Apnea

Other:
_____
_____
_____

Gastrointestinal:
___ Crohn's / Colitis / Celiac
___ Acid Reflux / Ulcer

Genitourinary:
___ Kidney Disease
___ Prostate Disease / Cancer

Muscular/Skeletal:
___ Arthritis / Osteoarthritis
___ Fibromyalgia
___ Ankylosing Spondylitis

Integumentary (skin):
___ Eczema / Rosacea
___ Herpes Simplex / Zoster

Endocrine:
___ Type 1 / Type 2 Diabetes
___ Hypo / Hyperthyroid

Blood/Lymph:
___ Anemia
___ High Cholesterol

Allergy/Autoimmune:
___ Environmental Allergies
___ Lupus / Sjogren / RA

None of the above _____

Family Medical Information

Please indicate which, if any, of the following medical conditions are present in your family's medical history:

Cancer	__ Yes	__ No	Relation _____
Type 1 Diabetes	__ Yes	__ No	Relation _____
Type 2 Diabetes	__ Yes	__ No	Relation _____
Hyperthyroidism	__ Yes	__ No	Relation _____
Hypothyroidism	__ Yes	__ No	Relation _____
High Blood Pressure	__ Yes	__ No	Relation _____
Macular Degeneration	__ Yes	__ No	Relation _____
Cataract	__ Yes	__ No	Relation _____
Glaucoma	__ Yes	__ No	Relation _____

Other _____

Thank you for choosing Blink!

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Do you have any specific questions/concerns you would like addressed at this visit?

_____
_____
_____

*Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company, NOT Blink Eye Care & Eye Wear. If your insurance company has not reimbursed our office in full within 90 days, you will be responsible for full payment.

Signature:_____

I have read and agree to the HIPAA Policies.

Signature:_____

Payment is required at time of service.

*Your retina located in the back of your eye is the only place in the body where blood vessels can be seen directly. This means that in addition to eye conditions, signs of other diseases (for example, high blood pressure and diabetes) can also be seen in the retina. Early signs of these conditions can show on your retina long before you notice any changes to your vision or feel pain. A thorough evaluation of the retina is critical to verify that your eyes are healthy.

***Our doctors require Optomap Digital Retinal Imaging. This is the best way to monitor the health of your retina. There is a $39.00 copay.**

Signature:_____

CONTACT LENS PATIENT AGREEMENT

Please read and sign if you are a current contact lens wearer or are considering contact lenses.

THE COMPREHENSIVE EYE EXAM

Before a person can be fit with contact lenses, a comprehensive eye examination is necessary. This exam is critical to assure the health of your eyes and to rule out any condition that may prevent contact lens use. **Contact lens prescriptions cannot be renewed without an annual exam.**

CORNEAL EVALUATION

Contact lenses are medical devices that require ongoing evaluation to ensure safe and comfortable wear. This evaluation is necessary and is *in addition* to your comprehensive exam and includes:

- Evaluation of current or new lenses on the eye
- Evaluation of cornea, conjunctiva, and eyelid health related to contact lens wear
- Progress checks related to contact lens prescription and fit

For first time wearers, the patient will be provided with personalized instruction concerning the safe care and usage of contact lenses. Upon completion of successful insertion and removal, the patient may begin wearing the contact lenses and we will schedule a follow-up appointment in a week.

We care about keeping your eyes healthy and comfortable for life!

*** This exam requires an additional fee that may or may not be covered by insurance ***

There is no charge for follow-up visits during the first 60 days. After that we will be glad to see you for a $70.00 office visit.

Signature:_____

Blink
Eye Care and Eye Wear