BLINK EYEWEAR & EYECARE

NEW PATIENT INFORMATION

GENERAL INFORMATION

Today's Date: _____

First Name: _____

Last Name: _____

DOB:_____

Employer (or School) _____

Occupation (or Grade): _____

Spouse (or Parent) Name:_____

Reason for Visit:_____

I AM INTERESTED IN:

- ☐ GLASSES
- ☐ SUNGLASSES
- ☐ CONTACT LENSES
- ☐ ORTHO-K INFO
- ☐ SPORTS VISION INFO

Please list any current issues with contacts or glasses:

_____

How did you learn about our office?

_____

**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 agreed to the HIPAA Policies.

Signature:_____

Payment is required at time of service.

How will you settle your account balance today?

☐ ***Cash*** ☐ ***Credit*** ☐ ***Check***

Part of your exam today includes dilation of the pupils which allows the doctor to check the health of the back of the eye.

Many diseases do not present with visual symptoms. Dilation allows the best view for the Doctor to detect any eye health problems.

Dilation may cause blurred vision and sensitivity to light for 4-6 hours

☐ ***Accept*** ☐ ***Decline***

Are you currently pregnant or nursing? ☐ ***Yes*** ☐ ***No***

Do you smoke? ☐ **Yes** ☐ **No**

LIFESTYLE

Please check the box next to any of the following that are applicable!

Do you...

- ☐ WORK AT A COMPUTER
- ☐ SPEND TIME OUTDOORS
- ☐ HAVE PRESCRIPTION EYEWEAR
- ☐ PREFER NOT TO WEAR YOUR GLASSES OR CONTACTS AT TIMES?
- ☐ HAVE MORE THAN ONE PAIR OF CURRENT PRESCRIPTION WEAR?

MEDICAL HISTORY

Name of Physician: _____

City/State:_____

Date of Last Physical Exam:_____

CURRENT MEDICATIONS: *Please list all active medications including eye drops, vitamins/supplements, and birth control pills.*

_____

_____

Please list any allergies to medications, if applicable:

_____

Have you ever been diagnosed with or treated for any of the following health problems?

	YES	NO
Allergies	☐	☐
Arthritis	☐	☐
Blood/Lymph	☐	☐
Bronchitis	☐	☐
Cancer	☐	☐
Diabetes	☐	☐
Ear/Nose/Throat	☐	☐
Endocrine	☐	☐
Eczema/Rashes	☐	☐
Fatigue	☐	☐
Genitourinary	☐	☐
High Blood Pressure	☐	☐
Integumentary (Skin)	☐	☐
Kidney	☐	☐
Muscle/Bone	☐	☐

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NEW PATIENT INFORMATION

NEUROLOGICAL	☐	☐
PSYCHOLOGICAL	☐	☐
RESPIRATORY	☐	☐
SINUS	☐	☐
THYROID	☐	☐
UNUSUAL WEIGHT GAIN/LOSS	☐	☐

OTHER:

OPTOMETRIC HISTORY

Date of Last Eye Exam:_____

Previous Provider: _____

Have you tried contact lenses before? ☐ *Yes* ☐ *No*

Do you currently wear contact lenses? ☐ *Yes* ☐ *No*

If so, what kind?

_____

What kind of solution do you use?

_____

Are you satisfied with both the vision and comfort of your contact lenses?

☐ *Yes* ☐ *No*

Have you ever had eye surgery? ☐ *Yes* ☐ *No*

If yes, please specify:_____

FAMILY MEDICAL HISTORY

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

BLINDNESS	☐
CATARACTS	☐
CORNEAL PROBLEMS	☐
DIABETES	☐
GLAUCOMA	☐
HEART DISEASE	☐
LAZY EYE	☐
MACULAR DEGENERATION	☐
RETINAL PROBLEMS	☐

Thank you for choosing BLINK!
Do you have any questions/concerns you would like addressed at this visit?

_____
_____
_____

CONTACT LENS PATIENT AGREEMENT

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

Before a person can be fit with contact lenses, a comprehensive eye examination is necessary. This exam is critical to assure the good health of your eyes and to rule out the possibility of any unsuspected, underlying 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, conjuctiva, and eyelid health related to contact lens wear
- Progress checks related to contact lens prescription

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 ***

CONTACT LENS TRAINING SESSION

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.
There is no charge for follow-up visits during the first 60 days. After that we will be glad to see you for a $45.00 office visit.

Signature:_____