

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

BLINK EYEWEAR & EYECARE
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? Y 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, conjunctiva, 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: _____



