Blink optometry

Patient Information

Full Name: _____ **Date of Birth:** _____ **Age:** _____ **Sex:** ☐ Male ☐ Female

Preferred Contact: ☐ Call ☐ Text ☐ Email **Phone:** _____ **Email:** _____

Address: _____

Employer/School: _____ **Position/Grade** _____

Hobbies/Interests: _____ **If a minor, Parent/Guardian Name**_____

Reason for Visit

1. What brings you in today? _____
2. Are you experiencing any of the following? (Check all that apply):

Billable to Medical Insurance

☐ Headaches ☐ Eye Pain/Strain ☐ Dryness

☐ Redness ☐ Flashes/Floaters ☐ Foreign Body

☐ Double Vision

Billable to Vision Insurance

☐ Blurred Vision ☐ Astigmatism

☐ Near-sighted ☐ Far-sighted ☐ Trouble Reading

☐ Other: _____

Note: Some symptoms may require a medical eye exam. If you're here for a routine vision exam, we may need to schedule a follow-up. In many cases, we can perform a medical exam today and bill your medical insurance. Please let us know your preference at the start of your appointment.

3. Do you wear corrective lenses? ☐ Glasses ☐ Contacts ☐ Both ☐ None

If contacts: **Brand:** _____ **Replacement Schedule:** _____

Contact lens exams require additional procedures resulting in an additional fee. Please consult front office staff for the exact cost.

Medical History

4. Have you been diagnosed with any of the following? (Check all that apply)

Eye Conditions:

☐ Cataracts ☐ Glaucoma ☐ Macular Degeneration ☐ Diabetic Retinopathy ☐ Retinal Detachment

☐ Eye Injury ☐ Eye Surgery ☐ Lazy Eye ☐ Dry Eye ☐ Other: _____

Systemic Conditions:

☐ Diabetes ☐ High Blood Pressure ☐ High Cholesterol ☐ Thyroid Disorder ☐ Asthma/COPD

☐ Heart Disease ☐ Autoimmune Disease ☐ Stroke ☐ Cancer ☐ HIV ☐ Other: _____

5. List current medications (including eye drops, supplements, vitamins): _____

_____

6. Any allergies to medications or other substances? ☐ Yes ☐ No

   If yes, please list: _____

7. Healthcare Providers:

   Primary Care Physician: _____

   Other Providers (specialists for systemic or eye conditions):

   Name: _____ Specialty: _____

   Name: _____ Specialty: _____

Family Medical History (Blood relatives only)

Glaucoma: ☐ Yes ☐ No Relation: _____
Macular Degeneration: ☐ Yes ☐ No Relation: _____
Cataracts: ☐ Yes ☐ No Relation: _____
Diabetes: ☐ Yes ☐ No Relation: _____
High Blood Pressure: ☐ Yes ☐ No Relation: _____
Cancer: ☐ Yes ☐ No Relation: _____
Other: ☐ Yes ☐ No Relation: _____

Social History

8. Do you smoke? ☐ Yes ☐ No If yes: ☐ Occasionally ☐ Daily ☐ Former Smoker
9. Do you drink alcohol? ☐ Yes ☐ No If yes: ☐ Occasionally ☐ Daily

Technology Use & Interests

10. Do you spend 4+ hours per day on digital devices? ☐ Yes ☐ No
11. Would you like more info about:

    ☐ Blue Light Protection ☐ LASIK Consultation ☐ Eye Health Supplements

    ☐ Contact Lens Options ☐ Prescription Sunglasses

Insurance Information

Vision Insurance Provider: _____ Member ID: _____

Medical Insurance Provider: _____ Member ID: _____

Primary Insured Name: _____ Relationship: _____

Authorization & Acknowledgment

I certify that the information provided is accurate to the best of my knowledge. I understand that this information is confidential and will be used solely for my care at Blink Optometry. I authorize the services provided and agree to pay any applicable co-pays, deductibles, or fees at the time of service. I understand that billing may be submitted to either my vision or medical insurance based on the nature of the visit, and that coverage and co-pays may vary depending on my plan and deductible.

Signature: _____ **Date:** _____