BLINK EYECARE

Patient Registration

Patient Information

Date: _____

First Name _____
Last Name _____
Day Phone _____
Mobile Phone _____
Email _____
Sex _____
Date of Birth _____
Social Security _____
Preferred Language _____

Address _____
City/State _____
Zip Code _____
Occupation _____
Work Phone _____
Race _____
Ethnicity *(Circle One)* Hispanic or Latino / Not Hispanic or Latino

Guardian Information *(If applicable)*

First Name _____
Last Name _____
Day Phone _____
Mobile Phone _____
Email _____

Date of Birth _____
Street Address _____
City _____
State _____
Zip Code _____

Insurance Information

MEDICAL INSURANCE

Insurance Company _____
Insurance Phone _____
Plan/ Group _____
Policy/ I.D No. _____
Policy Holder Name _____
Policy Holder Date of Birth _____

VISION INSURANCE

Insurance Company _____
Insurance Phone _____
Plan/ Group _____
Policy/ I.D No. _____
Policy Holder Name _____
Policy Holder Date of Birth _____

Financial Policy

It is the policy of Blink Eyecare that *payment is due in full at the time of service*. Our office gladly accepts All Major credit cards - subject to a 3% surcharge, cash, Sunbit, Care Credit and Affirm. If you would like to apply for financing, please see our front desk staff. Any balance remaining after insurance processing is the responsibility of the patient and must be paid within 90 days of notification. Unpaid balances within this period may be subject to additional fees and will be sent to collections. We charge a returned check fee of $50.

I hereby assign to Blink Eyecare all medical and insurance benefits to which I am entitled, including benefits from Medicare, private insurance, and any other applicable health plans. I hereby authorize Blink Eyecare to release any information necessary to secure payment from my insurance company or other applicable health plan.I understand that a quote or estimate of insurance benefits is not a guarantee of benefits or payment. I understand that copayments, deductibles, estimated cost-sharing amounts, and charges for non-covered options are due at the time of service understand that I am financially responsible for any portion of my care, products, or services that my insurance company does not pay, including denied, non-covered, or otherwise unpaid charges.

I certify that I understand cancellations on eyeglasses are not permitted as all eyeglasses are custom crafted for each patient with their unique prescription. I certify that I understand that there are no refunds or exchanges and that all sales are final unless covered under manufacturer warranty or office warranty programs/ policies.

Signature of Responsible Party _____Date_____

HIPAA Notice

Our *Notice of Privacy Practices* provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this acknowledgement. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

The summary Notice of Privacy Practices is available from our Front Desk.

If you wish for persons other than those released under normal operations as indicated in the Notice to receive confidential information that is now protected under this law you must release them in writing. Please indicate on your patient registration form spouse, or any family or friends whom you wish to be able to receive information about you. You may of course choose not to release anyone. You may also be more specific in your restrictions for the persons you have released, just provide that request in writing. Parents or Guardians of minor children do not need to be released.

List anyone who may obtain information on your behalf:

Name:_____Phone:_____ Relationship:_____

Name:_____Phone:_____ Relationship:_____

Name:_____Phone:_____ Relationship:_____

Name:_____Phone:_____ Relationship:_____

By signing this form, you are acknowledging that Blink Eyecare has made our Notice of Privacy Practices available to you for review and that we have offered you a personal copy.

Signature: _____ Date: _____

Vision History

Last Eye Exam: _____ Primary Care Physician: _____ Phone: _____

Do you have or have you ever been diagnosed with any of the following conditions? (circle all that apply)

Cataract	Age-related Macular Degeneration	Glaucoma
Diabetes	Diabetic Retinopathy	Dry Eye
Eye infection, inflammation, allergy	Floaters or Flashes of Light	Iritis or Uveitis
Retina defects or degenerations	Amblyopia	Strabismus

Please explain: _____

_____

Please list any addition information/ concerns: _____

_____

Do you currently wear eyeglasses? ____ yes ____no If yes how old is current pair? _____

Do you wear or are you interested in wearing contact lenses? _____

What brand do you wear? _____ How often do you replace them?_____

How old is current pair? _____What prescription are you wearing? _____

Are you interested in lasik vision correction? ____ yes ____no

Color Vision

Have you been diagnosed with color vision deficiency? ___ yes ___ no ___ unknown

Do you have any concerns about your color vision today? _____

_____

Lifestyle (optional)

How many hours a day do you spend on the computer? _____

Do you participate in any sports or extracurricular activities? _____

What are you currently doing to protect your eyes from UV exposure? _____

Do you have any vision needs that are not currently being met by your regular eyeglasses/contacts? _____

_____

Medical History

Do you have any of the following?

Arthritis	Heart Disease	Hypertension (high blood pressure)
Asthma	High cholesterol	Migraines/ headaches
Cancer	HIV	Multiple sclerosis
Diabetes	Thyroid disease	Other

Other: _____

Surgeries: _____

Please list any medications you are currently taking:

_____ _____ _____

_____ _____ _____

_____ _____ _____

List any allergies: _____

Family History

Please indicate any family history (parents, grandparents, siblings, children, living or deceased) for the following conditions:

Condition	Yes	No	?	Relationship to you
Blindness	☐	☐	☐	_____
Cataract	☐	☐	☐	_____
Glaucoma	☐	☐	☐	_____
Macular degeneration	☐	☐	☐	_____
Retinal detachment/disease	☐	☐	☐	_____
Cancer	☐	☐	☐	_____
Diabetes	☐	☐	☐	_____
High Blood Pressure	☐	☐	☐	_____
Thyroid Disease	☐	☐	☐	_____

Other (explain): _____

Referral Information

How did you hear about us? _____

Do you have any other questions or concerns for the doctor? _____