# PATIENT INFORMATION

(Please **PRINT** legibly and complete **ALL BLANKS**)

NAME:_____ DATE:_____

ADDRESS:_____ SEX:_____ AGE:_____ BIRTHDATE:_____

CITY:_____ STATE:_____ ZIP:_____ SOCIAL SECURITY#:_____

HOME PHONE:_____ CELL PHONE:_____

EMAIL ADDRESS:_____ HEIGHT_____ WEIGHT_____

TEXT APPOINTMENTS TO CELL PHONE? ☐Yes ☐No

RACE (You may choose multiple): ☐AMERICAN INDIAN ☐ASIAN ☐AFRICAN AMERICAN ☐CAUCASIAN ☐HISPANIC ☐PACIFIC ISLANDER ☐DECLINE TO SPECIFY

COMMUNICATION PREFERENCE: ☐E-MAIL ☐POSTAL ☐TELEPHONE

MARRIED: ☐YES ☐NO ☐DOMESTIC PARTNER ☐OTHER (Please Specify):_____

EMPLOYER'S NAME:_____ OCCUPATION:_____ WORK PHONE:_____

EMERGENCY CONTACT:_____ RELATIONSHIP:_____ PHONE:_____

HOW DID YOU FIND OUT ABOUT US? ☐WALK-IN ☐REFERRAL ☐INTERNET SEARCH ☐INSURANCE ☐YELP ☐OTHER

**IF REFERRAL/OTHER PLEASE LIST**:_____

## INSURANCE INFORMATION

HEALTH INSURANCE NAME:_____ MEMBER #:_____

GROUP #:_____

VISION INSURANCE NAME:_____ MEMBER #:_____

GROUP #:_____

RELATIONSHIP TO INSURED: ☐SELF ☐SPOUSE ☐CHILD ☐OTHER (Please Specify):_____

If relationship is other than SELF, please fill out the Insured information below

INSURED NAME:_____ INSURED DOB:_____

INSURED EMPLOYER'S NAME:_____ INSURED OCCUPATION:_____

## HEALTH INFORMATION

PERSONAL PHYSICIAN:_____ MEDICATIONS TAKEN DAILY:_____

LIST ALL DRUG ALLERGIES:_____

## WARRANTY & REFUND POLICY

All frame & prescription sales are final. No refunds are given.

**Opthalmic Lenses:**
All prescription lens sales are final, no refunds are given. Once the order is placed, the order is sent to the lab immediately. Therefore, any cancellations will be charges at full lab cost. If you experience any problems with your prescription lenses, please notify our office immediately so that we can address the problem. The Doctor may re-check the prescription as needed. New Lenses will be made within 60 days if necessary at no extra charge. This policy also applies to prescriptions written outside of our office, however there may be a fee to have the Doctor re-check the prescription. Changes made to the prescription over 60 days will be considered a new order and charged accordingly.

**Scratch Coat Warranty**: One-year Manufacturer's warranty from the date the prescription was made. This covers superficial scratches on the surface only and does NOT cover deep scratches to the lenses caused by mishaps such as dropping on the ground.

**Anti Reflective Coat Warranty:** One-year Manufacturer's warranty against peeling, cracking, or hazing from the date the prescription was made. This does not cover deep scratches to the lenses caused by mishaps as mentioned above. One redo per prescription.

**Frames Warranty:** One year warranty from the date of purchase against manufacturer's defects. This includes discoloration and failure at hinge points. This does not cover mishaps to the frame such as sitting on the frames or dropping on the ground.

**Accessories Warranty**: 30 days form the purchase against manufacturer's defects. No refunds given, exchange or store credit only.

**I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any glasses and/or contact lenses ordered or professional services rendered. I authorize payment to the physician. A copy of this assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or changes in any of the information provided on the patient information sheet. I also authorize this office to release my spectacle or contact lens prescription at my request.**

_____ _____

Signature (or parent/guardian's signature if patient is a minor) Date

**Wink Optometry** Gordon G. Wong, O.D. Wildon C. Wong, O.D.

# Privacy Notice

Wink Optometry Del Mar will not disclose your personal information or medical records except when absolutely necessary to provide appropriate medical care. At your request, we will provide you with a detailed copy of the Wink Optometry Del Mar Notice of Privacy Practices.

_____ _____

Signature Date
(parent or guardian if patient is a minor)

_____

Name (please print)

2673 Via De La Valle Suite F/E Del Mar, CA 92014 tel 858-755-9465
www.winksandiego.com

**Wink Optometry** Gordon G. Wong, O.D. Wildon C. Wong, O.D.

# Retinal Photography

The retina is the sensory tissue inside the eye and is responsible for capturing images, much like the digital sensor or film inside of a camera. A few eye diseases and systemic conditions that affect the retina include:

| | | |
|---|---|---|
| **Glaucoma** | **High blood pressure** | **Cancer** |
| **Macular degeneration** | **Diabetes** | **High myopia** |
| | **Arthritis** | |

In many cases, retinal problems do not have any symptoms and the affected person will not be aware that anything is wrong.

Your eye exam includes a retinal evaluation that is performed with the aid of dilating drops. When your pupils are dilated, you will be sensitive to light (because more light is getting into your eye) and you may notice difficulty focusing on objects up close. These effects can last for up to several hours, depending on the strength of the drop used.

You can choose to have retinal photographs taken instead of having your eyes dilated. The photographs will be taken using state of the art Optomap imaging technology. The images will be kept as a part of your records and the doctor can compare the images year after year at your annual examination. In some cases, the doctor may need to dilate your eyes in addition to taking the images.

- It is highly recommended that everyone, including children, have baseline photos taken
- No dilation of the eyes is necessary to perform this test
- The doctor will immediately analyze and review the photos with you during your exam.

Retinal photography usually is not completely covered by insurance.
The fee for retinal photography is $49 but may be discounted with insurance.

***I have read the information about Retinal Photography***

☐ Yes, I choose to have retinal photography performed at this time

☐ No, I will decline this test and I prefer to have my eyes dilated

**Name:** _____
(Please print)

**Signature:**_____ **Date:**_____
(Parent or guardian if patient is a minor)

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# Contact Lens Service Agreement

Contact lens wearers require a special evaluation and assessment by the doctor with varying levels of service (shown below) that are *not* part of the standard eye examination. These professional services are necessary every year in order for the doctor to adequately determine the up-to-date contact lens prescription for optimal ocular health, vision and comfort. Vision plans often do not fully cover the costs associated with elective contact lenses, except in certain cases that are deemed medically necessary (e.g. corneal disease, post-corneal transplant, etc.).

The fees below exclude the final supply of contact lens materials for regular wear.

Contact Lens Management Fees:

| | |
|---|---|
| Soft Sperical Exam | $125 |
| Sperical Rigid Gas Permeable Exam | $175 |
| Soft Astigmatism Exam | $175 |
| Astigmatism Rigid Gas Permeable Exam | $230 |
| Monovision Exam | $230 |
| Soft Multifocal Exam | $230 |
| Hybrid Duette Exam | $230 |
| Hybrid ClearKone Exam | $290 |
| Specialty Fit | $800 |

**All contact lens exams include up to 2 months of follow-up visits**

## New Contact Lens Wearers:

New contact lens wearers require training on insertion, removal, proper handling, and care of your contact lenses. You will be charged a one-time fee of $50.00 for this service. If you require additional training within the 2 month period of your follow up visits, there is no additional charge. Re-training after that period is elective and you will be charged the fee for this service.

## Payment Policy:

Unless otherwise stated, your full payment for professional services and materials are due on the date of your initial service. **The cost of professional time is non-refundable**. In the unusual event that you cannot wear the final contact lenses, you may return any contact lenses ordered through our office for a full refund within 60 days of dispensing. Return of disposable contacts must be in their original boxes, unopened, unmarked, and not expired. We are not responsible for contacts that are lost, stolen, or that you damage. In the event that you desire a contact lens exam or follow-up beyond the initial exam and 2 month follow-up period, and before your next yearly exam, you will be charged a $75.00 contact lens management fee for each office visit.

I hereby understand and will comply with the agreement of contact lens services offered by your office as stated above.

Patient Signature:_____ Date:_____

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