DR. RICHARD E. WINNICK, O.D. & ASSOCIATES

"The Doctors Next to LensCrafters"

Welcome!

We appreciate you selecting our office for your eye care needs. We will do everything possible to insure your satisfaction.

Mr. Miss Mrs. NAME _____ DATE _____ DATE OF BIRTH _____ AGE _____

ADDRESS _____ HOME PHONE _____ WORK PHONE _____

CITY/STATE/ZIP _____ OCCUPATION _____ EMPLOYER _____

IF CHILD, PARENT'S NAME _____ DATE OF LAST EXAMINATION _____ SOC. SEC. _____

I PREFER TO BE CALLED _____ DO YOU WEAR GLASSES _____ CONTACT LENSES _____

EMAIL _____

HOW DID YOU LEARN ABOUT OUR OFFICE? FAMILY MEMBER ____ FRIEND ____ T.V. AD ____ MAIL COUPON ____ WALK-IN ____ YELLOW PAGES ____ RADIO AD ____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

WHAT BRINGS YOU TO OUR OFFICE TODAY?

ROUTINE CHECK-UP _____

LOST OR BROKEN GLASSES _____

LOST OR TORN CONTACT LENSES _____

DISTANCE VISION BLURRY _____

NEAR VISION BLURRY _____

HEADACHES _____

EYES ITCH, BURN, WATER _____

CONTACT LENS PROBLEMS _____

REDNESS OR PAIN _____

FLASHES OF LIGHT _____

FLOATERS _____

PERIPHERAL VISION PROBLEMS _____

OTHER _____

MAY WE PROVIDE INFORMATION REGARDING THE FOLLOWING CONTACT LENSES?

GAS PERMEABLE HARD _____ SOFT _____

DISPOSABLE _____ BIFOCAL _____

ASTIGMATISM (toric) _____ TINTED _____

EXTENDED WEAR _____ DAILY WEAR _____

PLEASE TELL US ABOUT YOUR GENERAL AND OCULAR HEALTH INCLUDING FAMILY HISTORY. LIST ANY PRESCRIPTION MEDICATIONS NEXT TO THE APPROPRIATE CONDITION. (X = YOU, F = FATHER, M = MOTHER, S = SISTER, B = BROTHER)

	PATIENT	FAMILY	MEDS
DIABETES	____	____	_____
HIGH BLOOD PRESSURE	____	____	_____
HEART DISEASE	____	____	_____
ALLERGIES (Including Medications)	____	____	_____
CATARACTS	____	____	_____
EYE INJURIES	____	____	_____
EYE SURGERY	____	____	_____
STRABISMUS (crossed eyes)	____	____	_____
AMBLYOPIA (lazy eye)	____	____	_____
RETINAL PROBLEMS	____	____	_____
OTHER	____	____	_____

ACCOUNT WILL BE PAID:

_____ CASH _____ CHECK _____ VISA/MASTERCARD

DO YOU HAVE:

_____ MEDICARE _____ VISION INS. _____ OTHER COVERAGE

DILATED PUPIL EXAMINATION

The use of dilating agents is now the standard of a thorough eye examination and is the only way to assess the health status of your entire eye.

Dilation of the pupils is important for the inspection of the periphery of the eye for the presence of ocular disease, tumors, and/or retinal detachments and to investigate the causes of symptoms such as pain, flashes of light or "floaters" (floating spots in your vision). It is also important to fully diagnose cataracts or glaucoma and to monitor the effects of systemic diseases such as diabetes or high blood pressure.

While the drops used have no lasting side effects, please be advised that you may experience mildly blurred vision especially when reading and some sensitivity to light. The average duration of these effects is 3 to 4 hours but may vary between individuals. Complimentary sunglasses will be provided.

_____ I want a dilated pupil examination included today.

Signed: _____ **Date:** _____