eye-brain connection

Date: ________________

Name: ☐Mr. ☐Mrs. ☐Ms. ☐Dr. ____________________ / ________________ / ____ ☐Male ☐Female
Last First MI

Address: ______________________________ / ____________________ / _________ / _______
Street City State Zip

Birthdate: _____/_____/________ How did you hear about us? ________________________________

Home phone (______)____________ Work phone (______)__________Ext.______Cell (____)________

E-mail address (IMPORTANT): ____

Dr. Trinka ☐ has my permission/ ☐ does not have my permission to send me a monthly health email.

In case of emergency, contact: ________________ Phone: (_____)__________ Relationship: __________

Marital status: ☐Single ☐Married Social Security #: ____________________

Occupation: __________________________ Employer: ________________________________

Vision Insurance Information:

Insurance Company: ______________________________

Member's Name: ________________________________ Member's ID#: ______________________

Primary Care Physician: __________________________ Phone: ____________________________

Primary Care Physician Address: ____

Present Medical Condition/Symptoms: ____

____

____

Present Rx Medications: ____

Present Over-the-Counter medications: ____

Present Supplements: ____

Frequent Activities: Work related: ____

Recreational: ____

Why are you here to see us today? ____

PLEASE READ CAREFULLY

INFORMED CONSENT, AUTHORIZATION, DISCLAIMER AND RELEASE: I understand and agree that all services provided by Dr. Trinka shall be charged directly to me and that I am responsible for final payment of any such services regardless of insurance coverage, including, without limitation, Medicare coverage. I hereby authorize the release by Dr. Trinka of all information and records deemed necessary to secure payment or to benefit my health. I HAVE READ, UNDERSTOOD, AND AGREE TO THE ABOVE.

Signature: ____________________________________ Date: ___________________________

Date:______________

Lifestyle Questionnaire

Patient Name: ______________________________ Email address: ________________________

Cell Phone Number: _________________________ Occupation: __________________________

This questionnaire is designed to assist Dr. Trinka in helping you select the perfect lenses, frames and/or contacts to suit your visual needs and lifestyle (should you require visual correction). Please take a few moments to answer the following questions.

1. **Which of the following visual demands do you encounter on a regular basis?**
   (check all that apply)

☐ Artificial lighting
☐ Board work
☐ Close-up work
☐ Computer work
☐ Natural lighting
☐ Paperwork
☐ Potential eye hazards
☐ Reading
☐ Other

2. **Which of the following hobbies or activities do you participate in?**
   (check all that apply)

☐ Auto repair
☐ Biking
☐ Boating/water sports
☐ Bookkeeping
☐ Bowling
☐ Competitive sports
☐ Computer
☐ Drawing
☐ Driving
☐ Exercise
☐ Fishing
☐ Golf
☐ Home repairs
☐ Hunting/shooting
☐ Jogging/running
☐ Landscaping/gardening
☐ Musical instrument
☐ Painting
☐ Pilot
☐ Racquetball
☐ Reading
☐ Sewing/arts/crafts
☐ Snow sports
☐ Spectator sports
☐ Tennis
☐ Watching TV
☐ Welding
☐ Woodwork
☐ Other ________________________

3. **Do your eyes seem bothered by glare from any of the following situations:**

☐ Car headlights
☐ Computer monitor
☐ Fluorescent lights
☐ Haze
☐ Night Driving
☐ Sunshine
☐ Traffic lights
☐ Other ________________________

4. **If you wear contact lenses, do you have:**

☐ Current pair of prescription glasses
☐ Sunglasses (purchased at a boutique, department / optical store)
☐ Other ________________________

5. **Do you have any metal or silicon allergies?** ☐ Yes ☐ No

6. **What do you like about your current glasses or contacts (color, style, fit, etc.)?**

____

____

____

7. **What don't you like about your current glasses or contacts (weight, thickness, glare, etc.)?**

____

____

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I HAVE READ, UNDERSTOOD, AND AGREE TO THE ABOVE.

Signature: ____

Dr. Terence A. Trinka, O.D., CN
eye-brain connection
7steps2health

This form authorizes us to use and disclose your protected health information (PHI) for the purposes of healthcare operations including – treatment, payment activities, insurance, recall notices, and confirming of appointments.
Before signing, please read our Notice of Privacy Policies to gain a clear understanding of how we may use and disclose your PHI.
For questions concerning our Notice of Privacy Policies, please contact Dr. Trinka.

Patient's Consent

Name: ______________________________

Signature: ___________________________

I, ______________________________ have read your Notice of Privacy Policies and I consent to your use of my PHI for the purposes of healthcare operations including – treatment, payment activities, insurance, recall notices, and confirming of appointments.
If a personal representative on behalf of the patient signs this consent, complete the following:
Personal Representative's Name: ______________________________
Relationship to Patient: ______________________________________

Patient's Revocation
By signing below, you revoke your above consent for us to use and disclose your PHI. However, by doing so, we reserve the right to discontinue treatment for you. This revocation also does not negate any of our prior actions while acting under your consent.

Signature: ___________________________ Date: ____________

If a personal representative on behalf of the patient signs this consent revocation, complete the following:
Personal Representative's Name: ______________________________
Relationship to Patient: ______________________________________

This information is intended as advisory in nature and should not be considered as legal advice nor is it a substitute for legal advice. This information does not constitute technical information system/security advice. It is designed to assist you in your own risk management activities. It is not intended to be exclusively relied upon or used as a substitute for your own loss-control program. Accuracy and completeness are not guaranteed.