

**Patient Name** (Mr/ Mrs/ Ms/ Dr) \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zipcode \_\_\_\_\_  
 Phone (home) \_\_\_\_\_ (work) \_\_\_\_\_ (mobile) \_\_\_\_\_  
 Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN \_\_\_\_\_  
 Occupation & Employer \_\_\_\_\_  
 Emergency Contact \_\_\_\_\_ Contact Number \_\_\_\_\_  
 How did you hear about us \_\_\_\_\_

**DILATION should ALWAYS be done** because it allows for a thorough evaluation of your eyes. It is *NECESSARY* to detect many sight-threatening conditions. These eye drops enlarge your pupils and will increase your sensitivity to light and blur your near vision. Most patients are able to drive afterwards. The effects last up to eight hours; requires an additional 30 minutes. No additional fee.

**I have read the above** \_\_\_\_\_ **I'd rather NOT be dilated today** \_\_\_\_\_

**CONTACT LENS WEARERS:** I understand that contact lenses are a medical device regulated by the FDA. Contacts have a limited and controlled life-span. Like any medical device, proper care is necessary. I understand the necessity of follow-up care to monitor my health. I understand that the use of this medical device presents risk of possible infection and other complications **Initial** \_\_\_\_\_

**Reason for today's visit** \_\_\_\_\_

Do you have eyeglasses? Y / N \_\_\_\_\_ When did you last replace your eyeglasses? \_\_\_\_\_  
 Use glasses for (circle all that apply): Driving TV Computer Reading Hobbies

Do you currently wear contacts? Y / N \_\_\_\_\_ Would like to be fit with contacts today? Y / N \_\_\_\_\_  
 How often do you change your contacts? \_\_\_\_\_  
 What solutions do you use? \_\_\_\_\_  
 How many hours a day do you wear your contacts? \_\_\_\_\_  
 How many days a week do you wear your contacts? \_\_\_\_\_

List all your **allergies** (including medications) \_\_\_\_\_

Are you Pregnant? Y / N \_\_\_\_\_ Nursing? Y / N \_\_\_\_\_  
 Do you use: Alcohol Y / N \_\_\_\_\_ Tobacco products Y / N \_\_\_\_\_ Recreational drugs Y / N \_\_\_\_\_  
 Have you been infected with: Hepatitis  HIV  Herpes

Do you or anyone in your family have the following?

Cataract	Self <input type="checkbox"/>	Family <input type="checkbox"/>	Glaucoma	Self <input type="checkbox"/>	Family <input type="checkbox"/>
Macula Degeneration	Self <input type="checkbox"/>	Family <input type="checkbox"/>	Retina Detachment	Self <input type="checkbox"/>	Family <input type="checkbox"/>
Turned Eye	Self <input type="checkbox"/>	Family <input type="checkbox"/>	Lazy Eye/ Amblyopia	Self <input type="checkbox"/>	Family <input type="checkbox"/>
Color Blind	Self <input type="checkbox"/>	Family <input type="checkbox"/>	Double Vision	Self <input type="checkbox"/>	Family <input type="checkbox"/>

List previous eye surgeries & eye injuries? \_\_\_\_\_  
 List your eye drops & eye medications? \_\_\_\_\_

Do you have any of the following? (check all boxes that apply)

Arthritis <input type="checkbox"/>	Diabetes <input type="checkbox"/>	Depression/ Anxiety <input type="checkbox"/>
Heart Disease <input type="checkbox"/>	High Cholesterol <input type="checkbox"/>	High Blood Pressure <input type="checkbox"/>
Kidney Disease <input type="checkbox"/>	Thyroid Disease <input type="checkbox"/>	Auto-immune Disease <input type="checkbox"/>
Headaches <input type="checkbox"/>		Asthma/Lung Disease <input type="checkbox"/>
Cancer <input type="checkbox"/>	Type of Cancer & when _____	

List All your Medications: \_\_\_\_\_

By signing below, I agree that the above information is true/ accurate and constitutes a "signature on file" for your insurance company. I also certify that I have been notified about dilation and accept the consequences of refusal. I have been informed of Privacy Policies for protected health information. Office policy is payment at the time of service. We can provide you with forms for you to submit claims to your insurance company.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_  
 Parent/ Guardian if patient under 18 years old