

## PATIENT HISTORY UPDATE

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Employer/Occupation: \_\_\_\_\_

Insurance\*: \_\_\_\_\_

*\* All charges incurred are due at the time of service. Currently we do not accept vision insurance on assignment. However, we will provide you with a medical statement which many insurances will use to reimburse you directly.*

Did you receive our yearly postcard reminder? yes / no

If not currently wearing contacts, are you interested in trying them today? yes / no

## MEDICAL HISTORY

**Please check any condition that applies to yourself or any members of your immediate family:**

	Self	Family		Self	Family
Diabetes	_____	_____	Heart Problems	_____	_____
High Blood Pressure	_____	_____	Respiratory Problems	_____	_____

Medications you are currently taking? \_\_\_\_\_

What allergies do you have if any? \_\_\_\_\_

## REQUEST FOR EYE DILATION

### What is Dilation?

Dilation is a standard procedure which allows the doctor to fully evaluate the health of your eyes. This procedure is the standard of care for all healthy adults every two years. Dilation is recommended more frequently for patients who are nearsighted or farsighted; diabetic; experience flashes of light (like lightning); black spots, or headaches; cataracts; are at risk of glaucoma; and other high risk categories.

### What does it entail?

To perform dilation, the doctor places a few eye drops into each eye. The black circle in the center of each eye (the pupil) will enlarge in 10 to 15 min. The doctor will then use various lights and lenses to view the inside of your eyes. Your eyes will gradually return to normal over the next 4 to 8 hours.

### What happens then?

When your eyes are dilated, more light is able to enter the eye, therefore you may be more sensitive to light. Also, you may experience difficulty reading up close. For these reasons, many people choose to have this procedure performed later in the day, on a day off from work or school, or when someone else can drive them home. A free pair of sunshades will be provided.

### **Please check one of the following:**

Yes, if recommended by the doctor, I would like to have my eyes dilated today for an additional \$25.

No, I decline this procedure. I fully understand the reasons for dilation and accept full liability for consequences of not having this procedure performed.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_