WELCOME TO OUR OFFICE

NAME: _____ DATE: _____

ADDRESS: _____ CITY / STATE / ZIP: _____

DAY PHONE: _____ EVENING / CELL PHONE: _____

BIRTH DATE: _____ SOCIAL SECURITY #: _____

HEALTH INSURANCE: _____ PRIMARY INSURED: _____

RELATIONSHIP TO INSURED: MEMBER SPOUSE CHILD PRIMARY INSURED BIRTH DATE: _____

PRIMARY INSURED ADDRESS: _____ CITY / STATE / ZIP: _____

PRIMARY INSURED SOCIAL SECURITY: _____ LAST EYE EXAM: _____

HOW WERE YOU REFERRED TO US? _____ PREVIOUS PATIENT? YES NO

EMAIL: _____ EMPLOYER: _____

DILATION PROCEDURE: Dilation includes the use of topical medications to dilate the pupil of the eye, to detect disease such as glaucoma, retinal detachments, malignant growths, diabetic retinopathy, hypertensive retinopathy, etc… Having your pupils dilated is a painless procedure with some minor side-effects. These include: mild burning on installation of drops, sensitivity to light, inability to focus at near, and blurry distance vision for some patients. These side effects usually last no longer that 4 to 5 hours. Some patients find it difficult to drive, and thus must bring a driver with them. State law requires that all certified Optometrists must perform a dilated exam on:

- All new patients to our practice.
- All established patients who have previously not been dilated.
- All established patients who were previously dilated but deemed medically necessary to be again.

Dr. Fowler will do a dilated eye exam. If you find it inconvenient to have your eyes dilated at this visit, or wish not to have your eyes dilated, please indicate.
I understand the importance of having my eyes dilated and understand the possible side effects.
At this time **(PLEASE INITIAL):**

_____ YES, I agree to allow dilation.

_____ I would prefer to NOT have a dilated eye exam.

_____ I would prefer to RE-SCHEDULE the dilation procedure. * There will be a $30.00 charge for this visit.

ASSIGNMENT, RELEASE, AND OFFICE POLICY: I hereby authorize the physician to release any information required to process a health insurance claim. I also authorize my insurance benefits to be paid directly to the physician and I understand that I am financially responsible for all non-covered services. I authorize health insurance plans to be billed for medical exams. I understand that all fees and charges are final. This includes contact lens fitting fees. Refunds/exchanges will not be issued. Therefore, payment delay, dispute, and withholding will not occur. I will be responsible to pay any attorney, collection, and related fees should collection occur.

PATIENT SIGNATURE: _____ DATE: _____

NOTICE OF PRIVACY POLICY (HIPAA): I have received a copy of the Notice of Privacy Practices and I have read this consent and understand it. I understand that I have the right to restrict the use and disclosure of my health information. By signing below I consent to the use or disclosure of my health information for treatment, payment, and to conduct health care operations involving this office or related health care facilities.

PATIENT SIGNATURE: _____ DATE: _____

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