



### **Patient Information Form**

Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_

SSN: \_\_\_\_\_ Marital Status: \_\_\_\_\_

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

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

Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

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

Primary Care Physician: \_\_\_\_\_

Employment Status: \_\_\_\_\_ Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_

What do you currently wear: (Please circle)

Glasses      Contact Lenses      Specialty Contact Lenses      No Prescription

May we text or email you? \_\_\_\_\_YES      \_\_\_\_\_NO



### **Insurance Information**

Patient Full Name: \_\_\_\_\_

DOB: \_\_\_\_\_

SSN: \_\_\_\_\_

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

Member ID #: \_\_\_\_\_

Insured (Guarantor) Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Insured DOB: \_\_\_\_\_

Insured SSN: \_\_\_\_\_

Insured Place of Employment: \_\_\_\_\_

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

Member ID#: \_\_\_\_\_



## **Dilation/RetinaMap Consent**

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

\_\_\_\_\_ A dilated pupil exam is a highly recommended part of your comprehensive eye examination. It allows the doctor to better examine the retina (the inside of your eye).

Dilation is strongly recommended for the following patients:

- 1) Those who are over 40 years of age;
- 2) Those who have high prescriptions.
- 3) Those diagnosed with diabetes, high blood pressure, heart disease or any other systemic health conditions.

**This will last between 4-6 hours**

\_\_\_\_\_ This advanced technology is highly recommended and used to detect early signs of retinal disorders, including but not limited to; glaucoma, cancer, diabetic retinopathy, high blood pressure, macular degeneration, and retinal detachment.

It is fast and painless.

It is particularly helpful when you return for your annual exam as it provides a permanent record of your retinal condition, and each subsequent year the RETINAMAP images can be viewed side by side to discover subtle changes and monitor your continuing eye health.

It does not take the place of dilation, but in most cases, dilation will not be necessary with pictures.

This is **NOT COVERED** by insurance plans unless we are actively following pathology.

**There is a fee of \$35.00 associated with the testing.**

**Please initial the line of the option that you prefer and sign below for consent.**

**Patient/Guardian Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_