PATIENT REGISTRATION

Name:______________________ Sex :□ M □ F Date of Birth:____/____/____Age:______SS#______________

Email:_______________ How would you like appointment reminders? □ Call □ Text (___)_____-_____ Marital Status: □ Single □ Married □ Widowed □ Divorced

Address_________________________________City_______________ State__________Zip__________

Home Phone: (___)_____-_____Cell: (___)_____-_______ Emergency Contact Name/phone # :_______________________

Relationship ___________________

Employer:_________________________Occupation:_____________________

Primary Care Dr:____________________________Referring /Specialty Dr.__________________________

Race: □ American Indian /Alaska Native □ Other □ White □ Black/African American **Ethnicity:** □ Hispanic □ Not Hispanic **Language:** □ English □ Spanish □ Russian □ Vietnames □ Other ___________

INFORMATION AND CONSENT FOR PUPIL DILATION

Pupil Dilation is essential for full medical evaluation of the eye. This requires the placement of multiple eye drops. Dilation causes an inability to focus on near objects or reading material, which can make close work very difficult. Dilation may cause difficulty driving or operating heavy machinery. These activities should only be done with great caution after dilation. Dilation may also cause some unsteadiness in walking. Please ask for assistance if you feel uncomfortable. These side effects can last for several hours afterward.

Very rarely, dilation of the pupils can induce a type of glaucoma in people who are susceptible to this problem. We check for signs that you might be predisposed to this type of glaucoma prior to receiving dilation drops. Signs of acute glaucoma include redness, severe pain, nausea, loss of vision. If any of these occur after dilation, you should call the office immediately.

I give my consent for pupil dilation during any and all of my visits to this office if it is necessary.

⇨ _________________________ Relation to Patient:____________Date:____/_____/ _____

OR

I refuse dilation knowing that my exam will be less comprehensive.

⇨ __________________________ Relation to Patient: ___________Date:____/_____/_____

NOTICE OF PRIVACY PRACTICE

My medical information can be shared with: _________________________________

Relationship: ____

Address: ______________________ Phone #: _______________

I acknowledge that I have received and reviewed a copy of the "Notice of Privacy Practices" which describes how Eyesight and Surgery Associates may use and disclose my healthcare information and how I can gain access to my information.

Signature ⇨ _________________________ Relation to Patient:____________Date:_____/______/ ______