A BRIEF NOTE ABOUT DILATION

The pupil is the black round center of the eye, which normally responds to the doctor's instrument lights by getting very small. This limits how much of the retina the doctor can view. By placing drops in the eyes the doctor enlarges or 'dilates' the pupil, thus increasing the amount of retinal tissue examined. Therefore, many eye diseases cannot be detected without dilation. It is necessary in determining the eye's health in patients who have a family history or personal history of **diabetes**, **high blood pressure**, or **retinal disease**. Patients who have experienced **flashes and floaters, double vision**, **vision changes**, **high amounts of near-sightedness** and **headaches** also require dilation.

NOTE: There are two side effects that occur when we dilate the eyes. ***For approximately 3 to 4 hours after the drops are instilled, you will be very sensitive to sunlight.*** We have dark shades that we can provide for you if needed. The shades will fit over your regular glasses if you require a prescription for distance. ***You may also experience an inability to focus for near objects*** such as computer screens, memos, etc. This will last ***approximately 2 to 3 hours.*** Certain patients who are nearsighted may simply remove their glasses and are able to see up close during this time. If there are any questions regarding the procedure, please ask the doctor for his guidance. ***DR. BRYAN STRONGLY RECOMMENDS DILATION TO ALL OF HIS PATIENTS.***

The fee for dilation is $15*. Please initial next to <u>only one</u> of the following choices:

_____ Yes, I want to have my eyes dilated today. I have read and understand the explanation of this procedure.
(INITIALS)

_____ I want to have my eyes dilated but not today. I will call your office to schedule dilation at a later date.
(INITIALS)

_____ No, I do not want my eyes dilated. I understand the inherent risk in refusing this procedure.
(INITIALS)

***Dilation is included as part of the comprehensive eye examination at no additional charge for patients covered by insurance, including EyeMed Vision Care and Cole Managed Vision members.**

HIPAA PRIVACY

Acknowledgment of Receipt of Privacy Notice

By signing this acknowledgment of Receipt of Notice of Privacy Practices (the "Notice"), I acknowledge and agree that I have received a copy of the Notice of Privacy Practices for review and to keep for my records on the date identified below.

I understand that the Location may use and disclose necessary personal health information (for example, my name, address, subscriber identification number, eye exam information and/or type of products provided) to another party to permit the Location to perform its administrative duties, provide me with eye care services and products, process my vision benefit claims and communicate with me regarding vision care services provided by the Location (for example, mailings of exam reminders or information about services/products provided by the Location).

I can be assured that this Location does not sell my personal health information of any kind to a third party for such party's own use. I authorize the Location to submit my vision benefit claims to my plan sponsor or health plan to receive reimbursement directly for the vision services and products that I have received from the Location.

_____ _____

Patient Signature or Patient's Legal Representative Date

Refusal of Acknowledgment

For Office Use Only

For Location Use ONLY: This section is to be completed by the Location only if unable to obtain the patient or patient's legal representatives written acknowledgment of the Notice of Privacy Practices for the following reasons:

_____(Please initial here) Patient or Patient's legal representative refused to sign.

_____(Please initial here) Other: (Please specify, e.g., emergency care)

_____

_____ _____ _____

Provider/Associate Name (Print) Provider/Associate Signature Date

NOTE: Place this form in the Patient's file and retain indefinitely.

MEDICAL HISTORY FORM

NAME: _____ TODAY'S DATE: ____/____/_____ HOME PHONE: _____

ADDRESS: _____ BIRTH DATE: ____/____/_____ CELL PHONE: _____

CITY: _____ ZIP:_____ SOCIAL SECURITY:____/____/_____ WORK PHONE: _____

EMAIL: _____ EMPLOYER: _____ OCCUPATION: _____

GUARDIAN (If patient is a child): _____ PAYMENT METHOD (circle one): CASH CHECK CREDIT CARD

MEDICAL DOCTOR: _____ LAST PHYSICAL: ____/____/_____ LAST EYE EXAM: ____/____/_____

MEDICATIONS - List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies): _____

_____

Do you have any allergies to medications? ❑ no ❑ yes If yes, explain: _____

INSURANCE INFORMATION (Please present your insurance card(s) so that we may make a photocopy for our records)

VISION INSURANCE CARRIER: _____ MEDICAL INSURANCE CARRIER: _____

MEMBER ID# _____ MEMBER ID#: _____

POLICYHOLDER: _____ POLICYHOLDER: _____

PATIENT'S RELATIONSHIP (circle): SELF SPOUSE CHILD OTHER PATIENT'S RELATIONSHIP (circle): SELF SPOUSE CHILD OTHER

POLICYHOLDER'S BIRTH DATE (if different from patient) ____/____/_____ POLICYHOLDER'S BIRTH DATE (if different from patient) ____/____/_____

PLAN#:_____ GROUP#:_____ PLAN#:_____ GROUP#:_____

PAST, FAMILY and/or SOCIAL HISTORY

Is there anything in your past history, family history or social history which would help us care for you? (If yes, explain)

- Past History (illness, operations, injuries, medications, treatments) [ ] N [ ] Y_____
- Family History (diseases, hereditary, risk factors, glaucoma) [ ] N [ ] Y_____
- Hobbies_____

Do you use any of the following products? Tobacco [ ] Y [ ] N Alcohol [ ] Y [ ] N Recreational Drugs [ ] Y [ ] N

Eye drops [ ] Y [ ] N (if yes, what type – circle one) prescription over-the-counter brand _____How often?_____

Do you want a prescription for contacts? [ ] Y [ ] N Have you worn contacts before?[ ] Y [ ] N If yes, circle what type and list brand below:

[ ] Disposable Lenses 1 day 2 week 1 month [ ] Rigid Gas Permeable Brand of Contacts_____

- If you wear disposable contacts, how often do you throw them away? _____ Do you sleep in your contacts? [ ] N [ ] Y
- What is the total amount of time you wear your contacts before disposing them? _____hours per day _____days per week _____weeks per month
- What type of contact solution do you use? [ ] Optifree [ ] Renu [ ] Complete [ ] Generic Multipurpose

Are you interested in having surgery to correct your vision (LASIK, PRK, other)? [ ] Y [ ] N

Have you had or do you currently have the following conditions? (circle all that apply – list details of condition, frequency, etc.)

Glaucoma Retinal Detachment Eye Injury Vision Therapy Eye Surgery Cataracts Chronic Eye Infections

Allergies/Hayfever Diabetes High Blood Pressure Migraines Seizures Rheumatoid Arthritis HIV Cancer – list type (s)

_____

WHAT BRINGS YOU TO OUR OFFICE TODAY? _____

ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING PROBLEMS?

	Y	N		Y	N		Y	N
FLASHES	[ ]	[ ]	LAZY EYES	[ ]	[ ]	DRY EYES	[ ]	[ ]
FLOATERS	[ ]	[ ]	TIRED EYES	[ ]	[ ]	WATERY EYES	[ ]	[ ]
BLINDNESS	[ ]	[ ]	HALOS	[ ]	[ ]	BURNING EYES	[ ]	[ ]
SUDDEN LOSS OF VISION	[ ]	[ ]	GLARE/LIGHT SENSITIVITY	[ ]	[ ]	ITCHY EYES	[ ]	[ ]
DOUBLE VISION	[ ]	[ ]	DISTORTED VISION	[ ]	[ ]	MUCOUS DISCHARGE	[ ]	[ ]
BLURRED VISION	[ ]	[ ]	EYE PAIN OR SORENESS	[ ]	[ ]	SANDY OR GRITTY FEELING	[ ]	[ ]
HEADACHES	[ ]	[ ]	RED EYES	[ ]	[ ]	SWOLLEN EYES/EYELIDS	[ ]	[ ]

CONSENT FOR TREATMENT: I/We hereby authorize **Conrad Bryan, O.D.** to administer diagnostic and medical procedures as may be necessary for proper health care.

OFFICE POLICY ON PAYMENT: I understand that I am responsible for payment of all charges. As a courtesy, my insurance will be billed for me. It is my responsibility to pay any deductible, copay or any other balance not paid for by my insurance company. I authorize insurance benefits to be paid directly to the provider.

SIGNATURE (Patient over 18 years or Responsible Party) _____ DATE_____

PLEASE READ AND SIGN REVERSE SIDE OF FORM Doctor's Signature _____