PATIENT INFORMATION

(PLEASE PRINT) **(New____ Update____)**

PATIENT:

First Name ______________________________ MI ______Last Name__________________________________

Street Address________________________________City___________________State_____Zip_____________

Home Phone _________________Cell Phone ________________Birth Date ____________ Sex: M F

Social Security #_______________________ Email____

Employer ____Work Phone___________________

Occupation____

Marital Status (Circle) Single Married Ethnicity (Circle) White Black Asian Hispanic

Referred by____

RESPONSIBLE PARTY:

Name_________________________________Birthdate_____________Relationship to Patient______________

Address (If different than above) ____

DILATION OF PUPILS

In the course of a comprehensive eye examination it is imperative that the internal structures of the eye be thoroughly examined for disease or abnormality. In most cases, this is accomplished using eyedrops that enlarge the pupils (dilation). <u>There is no additional charge for dilation</u>. Dilation usually lasts from 4 to 6 hours. During that time you may experience some mild blurring of your vision, light sensitivity and difficulty reading. Most patients have no trouble driving or returning to work while dilated, however, please exercise caution. We are happy to provide disposable sunwear at no charge. If you choose not to be dilated, please let us know.

I have read and understand the above information. I have received a copy of RICHARDSON EYE ASSOCIATES' Notice of Privacy Practices.

Patient/Parent Signature____Date_________________

PATIENT / FAMILLY MEDICAL and EYE HISTORY (New____ Update____)

Patient Medical History (Circle all that apply)

Diabetes (Type 1 2) High Blood Pressure High Cholesterol Cancer Thyroid (Hyper/Hypo) Arthritis

Multiple Sclerosis Heart Disease Other:____

Patient Eye History (Circle all that apply)

Glaucoma Macular Degeneration Cataracts Dry Eyes Allergies Lazy Eye Surgery Injury

Other: ____

Do you wear: Glasses Soft Contacts Gas Permeable (Hard) Contacts

Family Medical and Eye History (Circle all that apply and give relationship)

Diabetes ______________Heart Disease________________Cancer_______________Glaucoma________________

Macular Degeneration ______________Other Eye Conditions____

Patient's Current Medications (please list dosage if known)

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Drug Allergies? ____

Do you: Drink Alcohol ______ Smoke______ Past Smoker______ Use recreational drugs_______