**Patient Demographics**

**Last name**       **First name**

**Date of Birth**       **Cellphone number**       **Email**

**Address**

**Emergency contact**       **Phone number**

To evaluate the health of the retina, please choose one of the following:

[ ] Optomap Retinal Images *This technology helps the doctor better detect/manage ocular and systemic diseases such as diabetes, high blood pressure, and high cholesterol. Optomap imaging does NOT have side-effects such as blurry vision and light sensitivity since no medications are used. Additional fee.*

[ ] Dilating Drops *Dilating drops are used to dilate or enlarge the pupils of the eye to allow the optometrist to get a better view of the inside of your eye. Dilating drops frequently blur vision for a length of time, which varies from person to person. They may also make bright lights bothersome. It is not possible for your optometrist to predict how much your vision will be affected. Driving may be difficult immediately after an examination, so it is best if you make arrangements not to drive yourself when you leave our office. If your child is dilated, he/she will have difficulty in completing schoolwork and homework. In addition, he/she should not participate in contact sports on the day of dilation. Like other medications, dilation drops may have side effects or cause allergic reactions.*

*I hereby authorize the doctors at Precision Optometric Care to administer dilating drops. I understand that eye drops are necessary to diagnose my condition and/or examine my eyes and that dilating drops may be put into my eyes each time I am examined or treated at Precision Optometric Care.*

*Signature for consent to drops: Date:*

HIPAA: Notice of Privacy Practices

*I acknowledge, by my signature below, that I have been given the opportunity to review the Notice of Privacy Practices, and I understand that I may request a copy of this notice should I so choose. I agree to electronic communication of appointment reminders as indicates above and outlines in the Notice of Privacy Practices.*

Patient or Guardian Signature: Date: