



WELCOME BACK TO OUR OFFICE

Personal Information:

Date: _____

Name: _____

Address Changes: _____

Phone Changes/Additions: (hm) _____ (cell) _____ (wk) _____

Email Changes/Additions: _____ (Your email will never be released.)

Insurance Changes: VSP VCP EyeMed None Occupation Changes _____

This eye examination is for: Glasses Contacts Other

Did you have your eyes examined anywhere else since your last exam here (including specialists) _____

Any issues with your eyewear/contacts from your last visit? _____

Patient History:

Any new medical conditions? _____

Any medication changes? (added or stopped)(please include vitamins/supplements) _____

Any eye infections since your last visit? _____

Other pertinent history _____

New known drug or environment allergies: _____

Family History: (Any new developments?): _____

In case of an emergency, whom may we call today?

Name _____ Phone _____ Relationship _____

Patient/Parent Signature _____ Date _____



THE **EYEDOCTORS** OF NEW TAMPA
19062 BRUCE B DOWNS BLVD. TAMPA, FL 34639

Informed Consent for Dilation of Eyes and/or Optomap®

Sight threatening conditions can happen to individuals of all ages and usually without symptoms. A condition with the potential for partial or total loss of vision may exist and go undetected without Dilation and/or the Optomap Retinal Exam.

Please check which procedure(s) you would prefer:

- Dilation**
- Eye drops necessary
 - Sensitivity to bright light
 - Blurry Vision, mostly near
 - Lasts 4-6+ hours (depending on sensitivity)
 - May not be able to drive or go back to work/school
 - Doctor examines retina and then makes notes in chart
 - Included in eye exam price
- Optomap® Retinal Exam**
- No drops
 - No blurry vision or any other side effects
 - Can resume normally activities after exam
 - Digital retinal image stored on computer for future comparison & baseline
 - Doctor reviews with patient during examination
 - OCCASIONALLY may still need dilation to examine other structures
 - Additional fee of \$39 (not covered by insurance)
- Would like to Discuss with Doctor**

Patient Printed Name _____

Signature (Patient/Guardian) _____ Date _____

In order to save time and provide the best eye care possible we pre-screen all patients with the Optomap®.