CENTRAL PARK VISION CENTER

DATE_____

Name_____ Birth Date_____
Address_____
City_____ State_____ Zip_____
Hm Phone_____ Cell Ph_____
Wrk Ph_____ E-Mail_____
Employer/Occupation_____
Insurance_____ SS#/ID#_____
Name of Primary Insured_____ SS#/ID#_____ D.O.B._____
Name of Parent If Patient Is a Minor_____

Visual & Medical History

Date of last eye exam_____ By_____
Reason for today's visit_____
Contact Lenses type_____ Disinfection Type_____
Who is your family Doctor?_____

Check any condition that applies to yourself (s) or immediate family (f):

Diabetes_____ Retinal detachment_____
High blood pressure_____ Eye surgery_____
Heart Problems_____ Glaucoma_____
Cancer_____ Lazy eye_____
Respiratory problems_____ Double Vision_____
Thyroid problems_____ Blindness_____
Kidney problems _____ Macular Degeneration_____
Liver problems_____ Head/Eye injury_____
Other_____ Cataracts_____

What medications do you regularly take?_____
_____
_____
What allergies do you have to medications?_____
_____
Do you have any interest in wearing contact lenses?_____
Have you been told that you can not wear contacts because of astigmatism or any other problem?_____
Do you have any interest in laser eye surgery?_____
Who referred you to us?_____
How would you prefer to be reminded of your future appointments? __Call ___ Text __ Email
*I have reviewed / received notice of privacy practices? (initial)_____

I agree to be responsible for payment of goods and services rendered inclusive of any insurance benefits I am entitled to. **Please sign below**.

_____

Dilation: Explanation & Authorization

Dilation involves putting medicated drops into the eyes. These drops open the pupils so that the doctor is better able to view the internal structures of the eye and give an accurate assessment of ocular health. The side effects of the drops may include a slight stinging or burning sensation upon the instillation, sensitivity to outdoor or bright light, and blurry vision. Some people feel uncomfortable driving when dilated. Precautions should be taken with steps, stairs, and especially with driving. These effects can last for several hours. Although we feel this is important to perform this test, if for some reason you wish to not have this test done, you may defer this test to a later date. I understand that by not performing this test it is possible to miss findings that could lead to visual / health problems. I furthermore agree to hold this office and staff harmless for any deleterious outcome. We will be willing to perform the dilated examination within a one-month period at no extra cost.

Please sign where appropriate below.

_____ _____

Yes I wish to be dilated **No I do not wish to be dilated**

24-HOUR COURTESY CALL

It is our desire to provide each patient with the highest quality service, in the most expeditious manner. Therefore, we provide a reserved time slot for each patient in order that there is minimal waiting and maximum continuity in service. In order to provide this service, we ask that you call 24 hours in advance or (in an emergency) up to a half hour before your appointment time if you are unable to keep your scheduled appointment. In the event that a person demonstrates a pattern of disregard for this policy, a charge of $25.00 per no showed appointment may be assessed. This includes follow up appointments. We appreciate the opportunity to serve you, and are constantly striving to improve our services. Thank you for this consideration of our staff and other patients.

_____ _____

Patient Signature **Witness Signature**

Computerized Visual Field Screening Test

This visual field computer can detect vision loss much like a "cat scan" specifically for the eye. The visual field analyzer detects diseases affecting vision such as pituitary tumors, glaucoma, macular degeneration, optic nerve disorders and retinal disturbances due to vascular problems or medications that may go undetected during routine examinations. This procedure requires an additional 5 to 10 minutes with an additional fee of 20.00 for the screening test.

_____ _____

Yes, I want to do the screening **No, I do not want to do the Screening**