Patient Information Sheet Name: _____

Date: _____ Email Address: _____

Social Security #: ____-____-_____ Sex: M F Cell Phone: _____

Address: _____ City/State: _____ Zip: _____

Birthday : _____ Home Phone: _____

Employer: _____ Work Phone: _____ Vision Insurance: _____

Insurance Holder/Parent/Guardian: _____ **Insured SS#:** _____

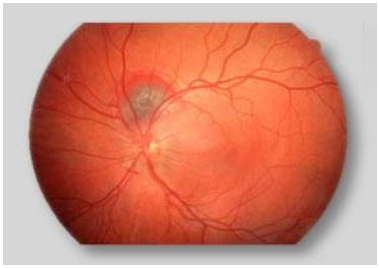
Insured Birthday: _____ Emergency Contact: _____

Do you currently wear? ◊Eyeglasses ◊Contact Lenses
If Contact lenses what type? ◊Clear ◊Color Brand of Contact lenses: _____
Solution: _____

I know everything in this section to be the most current & accurate information

Initial	Date

Retinal Photographs



A sophisticated camera now enables us to photograph and view your retinas. It is especially important for people with diabetes, high blood pressure, glaucoma, or any other eye problems. Some insurances will cover this procedure.

I wish to have retinal photography done at this visit

	Int, Date
Yes/No	
Yes/No	
Yes/No	
Yes/No	
Yes/No	

Pupil Dilation

Pupil dilation will require placing drops in your eyes which will open the pupil and allow a better view of the insides of your eyes. This procedure will add 20-30 minutes to the examination. There are some side effects to the drops including blurred vision and sensitivity to light rendering your ability to drive un-safe, therefore you will need to have someone drive you. The side effects usually last 6-8 hours.
By initialing in the box I indicate that I understand the importance of pupil dilation and the side effects. I am also choosing whether I want to have to this procedure done.

I wish to have pupil dilation done at this visit

	Int, Date
Yes/No	
Yes/No	
Yes/No	
Yes/No	
Yes/No	

Authorization, Release, Acknowledgement, and Payment Information

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor. I also acknowledge that all payment for professional services are due upon the completion of the examination. All contact lenses and eyeglass purchases must be paid in full before order will be completed. 1 Hour Optical does accept assignment of benefits for some insurance, however payment is the responsibility of the patient. Benefits can be obtained, but are coordinated by the insurance once submitted. All co-pays and deductibles are done upon the completion of the eye exam. We will need to make a photostatic copy of your insurance card (s) and a picture ID. Insurance can not be submitted without your social security number.

Parental/Guardian Consent: By signing below I am giving 1 Hour Optical full consent to care for the minor that I am the legal custodial parent/guardian of to the full scope of their licensure.

Signature of Patient (parent/guardian if minor) **Date**

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

We, the undersigned parent(s) or legal guardian(s) of the above-named minor, know that I may not be available to authorize medical care or purchases of said minor child & I wish to appoint someone to act in my place in my absence & to give such authorization. This authorization is intended to give _____ (name of guardian over 18) the right to give consent to authorize medical care and purchases.