



Edward G. Bryant, OD

Doctor of Optometry

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Patient's Name (please print) _____ **Date:** _____

If a child, name of parent/guardian _____ Relationship: _____

Spouse/Partner's Name: _____ Referred by: _____

Street Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

E-Mail _____ Date of Birth _____ M or F SSN _____

Preferred Contact Method: Home Cell Work Email Text

Occupation: _____ Employer/School _____

Do you have difficulties with any of the following systems?

- | | | |
|--|---|--|
| <input type="checkbox"/> Nervous system | <input type="checkbox"/> Mental | <input type="checkbox"/> Respiratory |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Cardiovascular | <input type="checkbox"/> Skin |
| <input type="checkbox"/> Ear/Nose/Throat | <input type="checkbox"/> Musculoskeletal | <input type="checkbox"/> Allergic/ Immunologic |
| <input type="checkbox"/> Genitourinary | <input type="checkbox"/> Endocrine (Glands) | <input type="checkbox"/> Blood/Lymph |

Do you have any of the following?

- | | | |
|-----------------------------------|---|-------------------------------------|
| <input type="checkbox"/> Contacts | <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Itchy Eyes |
| <input type="checkbox"/> Glasses | <input type="checkbox"/> Eye Injury | <input type="checkbox"/> Dry Eyes |

Dates and type of surgeries you have had: _____

Current medications: _____

Do you have any allergies to medications or other substances? Yes ___ No ___

Please list _____

Do you use tobacco? Yes ___ No ___ Alcohol? Yes ___ No ___ Other substances? Yes ___ No ___

If so, please list: _____

Name and phone number of primary care physician? _____

Do you or any of your blood relatives have a history of any of the following?

- | | | |
|--|--|---|
| <input type="checkbox"/> High Blood Pressure
Relation: _____ | <input type="checkbox"/> Diabetes
Relation: _____ | <input type="checkbox"/> Glaucoma
Relation: _____ |
| <input type="checkbox"/> Macular Degeneration
Relation: _____ | <input type="checkbox"/> Retinal Detachment
Relation: _____ | <input type="checkbox"/> Cataracts
Relation: _____ |

I certify that the information provided is complete and accurate to the best of my knowledge.

Signature _____ **Date** _____

If you are not the patient, what is your relation? _____

Over →

Assignment and Release

I hereby authorize my insurance benefits to be paid directly to the doctor and acknowledge that I am financially responsible for any unpaid balances. I also authorize the doctor to release any medical information necessary to provide the most beneficial and complete visual examination.

Acknowledgement of Receipt and General Consent

I acknowledge that I received a copy of Edward G. Bryant O.D.'s Notice of Privacy Practices.

I further consent to the release of my health information for purposes of treatment, payment and health care operations and as authorized or required by law under the circumstances in the Notice of Privacy Practices.

Authorization to Discuss Health Information

I authorize Dr. Edward Bryant to discuss my health information with the following:

Name _____ Relationship _____

Name _____ Relationship _____

Signature _____ **Date** _____

Do you dislike dilating eye drops?

Clarity Eye Care was the first in Ithaca to offer wide field digital retinal screening, called the OptoMap Retinal Exam. This instrument captures a specialized digital image of the back of your eye in a split second and allows Dr. Bryant to view a 200-degree panorama of your retina in the examination room. It is quick, requires no drops, and is as painless as having your picture taken. Best of all, you will be able to get back to your busy life without the blurred vision and light sensitivity!

Our patients come to us because they appreciate the thorough eye examination they receive.

Dr. Bryant recommends that children and adults make the OptoMap part of their annual eye health examination. Insurance will not cover this advanced screening. They would prefer you to have the dilation because it is less costly than the OptoMap experience. However, the fee for the screening is only \$35. Our patients agree that it is worth the investment in eye health.

I **elect** to have an OptoMap exam today. I **decline** the OptoMap and would prefer dilation.

Signature _____ **Date** _____