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PATIENT INFORMATION

(Please compete:)

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__________

Cell Phone______________ Home Phone______________ Work Phone ______________

E-Mail ______________________ Date of Birth ______________ M or F SSN ______________

Preferred Contact Method: Home Cell Work Email Text

Occupation: ______________________________ Employer/School ______________________________

Name and phone number of primary care physician?______________________________

Do you have difficulties with any of the following systems?

- ❑ Nervous system
- ❑ Headaches
- ❑ Ear/Nose/Throat
- ❑ Genitourinary
- ❑ Mental
- ❑ Cardiovascular
- ❑ Musculoskeletal
- ❑ Endocrine (Glands)
- ❑ Respiratory
- ❑ Skin
- ❑ Allergic/ Immunologic
- ❑ Blood/Lymph

Do you have any of the following?

- ❑ Contacts
- ❑ Glasses
- ❑ Blurred vision
- ❑ Eye Injury
- ❑ Itchy Eyes
- ❑ 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: ______________________________

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

- ❑ High Blood Pressure (Relation: ____________)
- ❑ Macular Degeneration (Relation: ____________)
- ❑ Diabetes (Relation: ____________)
- ❑ Retinal Detachment (Relation: ____________)
- ❑ Glaucoma (Relation: ____________)
- ❑ 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? ____

Assignment and Release

I hereby authorize my insurance benefits to be paid directly to the doctor. As the patient, parent, or legal guardian signed below, I understand that I will be receiving a bill for the services incurred today until I can provide accurate insurance information including the insurance name, policy number, policy subscriber information, and effective date of my coverage, along with a copy of my insurance card.

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!

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**____________________