



Edward G. Bryant, OD

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Doctors of Optometry

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www.bryantclarityeye.com

PATIENT INFORMATION

Please complete:

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 _____ [Text: YES / NO] Home Phone _____ Work Phone _____

E-Mail _____ [Email: YES / NO] 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 |

Name and phone number of primary care physician? _____

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: _____

Are you pregnant, or is there a possibility you may be pregnant? Yes ___ No ___

Are you currently breastfeeding? Yes ___ No ___

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: _____) |

BACK →



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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. Furthermore, I do assume responsibility for full payment pending any remaining balances not covered by insurance.

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 Image. 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** _____