Edward G. Bryant, OD
Kristy M. Dean, OD
Doctors of Optometry
1284 Dryden Rd
Ithaca, NY 14850
Phone: 607.257.1066
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www.bryantclarityeye.com

clarity
Eye Care with Dr. Bryant

PATIENT INFORMATION

Please complete:

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

Preferred Name (nickname): _____ Spouse/Partner's name: _____

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

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 (choose one): Home Cell Work Email Text

Occupation: _____ Employer/School _____

Referred by:_____ Previous Eye Doctor/Facility: _____

Do you have difficulties with any of the following systems?

- ❑ Nervous system
- ❑ Headaches
- ❑ Ear/Nose/Throat
- ❑ Genitourinary
- ❑ Gastrointestinal
- ❑ 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

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?

- ❑ High Blood Pressure
  - ❑ (Relation: _____)
- ❑ Macular Degeneration
  - ❑ (Relation: _____)
- ❑ Diabetes
  - ❑ (Relation: _____)
- ❑ Retinal Detachment
  - ❑ (Relation: _____)
- ❑ Glaucoma
  - ❑ (Relation: _____)
- ❑ 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 has been proud to be the first in Ithaca to offer routine wide-field digital retinal screening using an instrument called the **opto**map®. This instrument captures a specialized digital image of the back of your eye in a few moments and allows your doctor 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 blurred vision or light sensitivity—the most common side-effects of traditional dilation drops.

Dr. Bryant and Dr. Dean recommend that both children and adults make the **opto**map® part of their annual eye health examination. Though insurance will not cover this advanced screening, our fee for the **opto**map® is only $39, and our patients agree that it is worth the investment in their eye health.

___ I **elect** to have an **opto**map® exam today. ___ I **decline** the **opto**map® and would prefer dilation.

Signature_____**Date**_____