Edward G. Bryant, OD

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clarity
Eye Care with Dr. Bryant

www.bryantclarityeye.com

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_____ Home Phone_____ Work Phone _____

E-Mail _____ Please Choose Preferred Contact Cell Phone (Texting Avail)

Date of Birth _____ M ☐ F ☐ SSN _____

Occupation: _____ Employer/School _____

Referred by:_____ Previous Eye Doctor/Facility: _____

Name and phone number of primary care physician:_____

MEDICAL INFORMATION

Current Medications:_____

_____

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

Please list _____

Are you pregnant, or is there a possibility you may be pregnant? Yes ☐ No ☐ Currently breastfeeding? Yes ☐ No ☐

I currently use: ☐ **Glasses** ☐ **Contact Lenses** ☐ **Neither**

INSURANCE INFORMATION

Insurance Name: _____ Insurance ID # _____

Not Primary on account --- Primary Name on insurance is: _____

Address: _____

City _____State: _____Zip: _____

Phone number: _____ Date of Birth: _____

Relationship to Insured: Spouse ☐ Child ☐ Other ☐ Female ◯ Male ◯

Please Complete and Sign the back

BACK →

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?

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 optomap®. 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. Visco recommend that both children and adults make the optomap® part of their annual eye health examination. Though insurance will not cover this advanced screening, our fee for the optomap® is only $39, due at the time of service. Our patients agree that it is worth the investment in their eye health.

☐ I elect to have an optomap® exam today. ☐ I decline the optomap® and would prefer dilation.

Signature_____Date_____