

FAMILY HEALTH HISTORY

Please check any conditions that apply to your immediate family members:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Blindness | <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Cataract | <input type="checkbox"/> Retinal Detachment | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Crossed/Lazy Eyes | <input type="checkbox"/> Arthritis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney Disease | _____ |

HOW DID YOU HEAR ABOUT US? _____

ACKNOWLEDGEMENT OF RECEIPT

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. The *Notice of Privacy Practices* you have been given describes these uses and disclosures in detail.

I acknowledge that I have received the *Notice of Privacy Practices* from Diamond Vision Optometry, Inc.

Patient's Signature or Legal Guardian _____
Date

If signing as a personal representative, describe relationship to the patient and the source of authority to sign this form:

DILATION CONSENT

Dilated fundus examination is performed by optometrists and ophthalmologists as a routine part of an eye examination. It is a diagnostic procedure that employs the use of mydriatic eye drops to enlarge the pupil in order to obtain a better view of the fundus of the eye. Dilation has been found to be a more effective method for evaluation of internal ocular health, observing the retina more completely to rule out maladies such as glaucoma, retinal detachment, cataracts, eye tumors, and other sight or life threatening conditions. These eye drops require about twenty minute's time to fully dilate the pupil. We always prefer to have our patients driven after their dilation, as the eye drops may cause blurred vision and light sensitivity for up to six hours.

Please note, you will be made aware if your insurance plan does not cover this procedure.

Please check one:

_____ YES, I give permission to the doctor to perform dilation today.

_____ NO, I choose not to have dilation done. I understand that an exam of the retina through a dilated pupil is necessary to detect conditions that would otherwise be unobservable. These conditions, if undetected, may lead to partial or total vision loss.

_____ I prefer to schedule dilation to be done in the near future.

I authorize the eye doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependent during the period of such eye care to third parties payers and /or health practitioners.

I authorize my insurance company to pay directly to **Diamond Vision Optometry, Inc.**

I understand that my insurance carrier may not cover some services and products and benefit information does not constitute approval of payment. Deductible and fees not paid by my insurance carrier will be my sole responsibility. I also understand that there will be no refunds for rendered professional medical services related to eye exams or contact lens fitting or evaluations.

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Patient's Signature or Legal Guardian _____
Date

Doctor's Signature _____
Date