



PATIENT INTAKE FORM

Today's Date _____

Name: _____

Date of Birth: _____

Preferred Name: _____

(If patient under 18) Accompanied by: _____

Main reason for visit today: _____

Are you a diabetic? Y / N

(If yes) Have you had your yearly diabetic eye exam this year? Y / N

Are you pregnant or nursing? Y / N

Dilated exams are recommended regularly to view all the structures of the eye. The frequency of dilation that is advised varies depending on patient age, risk factors, and symptoms. The dilation enlarges your pupils and may cause blurred vision and light sensitivity for 4-6 hours.

Most patients are able to drive after dilation as it mostly affects near vision.

If you are **unable or decline** to be dilated at today's visit please sign below

Signature: _____

We offer Optos retinal imaging at our office.

The copay for this screening test is \$32.

This is HIGHLY recommended for patients who are opting out of dilation, but it is also an excellent supplement to a dilated exam. The doctor will review your photos with you during the exam.

I would like an Optomap scan today (\$32 copay)

I decline the optomap scan

Signature: _____