ZIGGY'S Optometry
NEWPORT BEACH

ESTABLISHED PATIENT INFORMATION – PLEASE PRINT

Last Name	First Name	Age

Cell Phone ( )	Email

Address change:	□ Yes	□ No	If yes, please update:		
Insurance change:	□ Yes	□ No	If yes, please update:		
Medical history / medication change:	□ Yes	□ No	If yes, please update:		
Do you drive?	□ Yes	□ No	Do you wear glasses?	□ Yes	□ No
Do you use tobacco products?	□ Yes	□ No	Do you wear contact lenses?	□ Yes	□ No
Do you drink alcohol?	□ Yes	□ No	Are you interested in contact lenses?	□ Yes	□ No
Do you use recreation drugs?	□ Yes	□ No	Are you interested in LASIK?	□ Yes	□ No
Are you pregnant?	□ Yes	□ No			

Reason for today's visit

DILATION CONSENT

Please read and check (✓) one of the following statements:

Dilated pupil examination helps the doctors to be able to more thoroughly examine the inside of the eye. It helps to detect hidden disease in the eye which may not cause symptoms but which could cause partial or total visual impairment or be life threatening. Patients with history of diabetes, high blood pressure, high cholesterol, autoimmune disease, cancer, retinal problems, glaucoma, macular degeneration, flashes or floaters, high prescription, or if their vision is not correctable to an acceptable level with no definitive cause are especially encouraged to have an annual dilation. You may experience blurred vision and will be sensitive to light for about 3 hours. Thus, daytime and nighttime driving may be impaired. Dilation may be scheduled for another day if necessary.

❒ **YES**. I want my pupils dilated today and am aware of side-effects of the procedure. I have read and understood the above.

❒ **NO**. I do not want my pupils dilated today. I understand that a condition with the potential for visual loss may exist, and it may go undetected without dilation. I have read and understood the above.

When was the last time you had an eye exam with dilation? _____ ❒ I have never had my eyes dilated.

_____ _____
Patient or legal guardian signature Date

OFFICE USE ONLY

Refusal of HIPAA acknowledgement:
[ ] Patient or patient's legal guardian refused to sign.

I have reviewed the patient information and ROS thoroughly.

_____ _____
Doctor signature Date