

# Patient Demographics

Today's Balance: \$ \_\_\_\_\_

Past Due Balance: \$ \_\_\_\_\_

Total Due Today: \$ \_\_\_\_\_

Account Number: \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_ Previous Name: \_\_\_\_\_

Address: \_\_\_\_\_ Apt #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_ Gender: \_\_\_\_\_

Preferred Phone

Home \_\_\_\_\_  Cell: \_\_\_\_\_  Work: \_\_\_\_\_

## Additional Info

Marital Status:

- Married
- Single
- Domestic Partner
- Widowed
- Divorced

Language:

- English
- Spanish
- Arabic
- Mandarin
- Other

Race:

- Alaska Native
- Asian
- Black / African American
- Native Hawaiian / Pacific Islander
- Decline

Ethnicity:

- American Indian
- White / Caucasian
- Hispanic / Latino
- Not Hispanic / Latino
- Decline

## Doctor Information

Referring Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Primary Care Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Specialist: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

## **Dilation Consent**

### **INFORMATION REGARDING DILATING EYE DROP**

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye.

Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it's best if you make arrangements not to drive yourself.

Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize my doctor and/or such assistants as may be designated by him/her to administer dilating eye drops. The eye drops are necessary to diagnose and treat my condition. I understand that, with rare exception, dilation is done on every visit at Retina Consultants of Michigan.

\_\_\_\_\_  
Patient (or person authorized to sign for patient)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date