# STRATFORD EYE CARE OPTOMETRY

Title: ☐ Ms. ☐ Mrs. ☐ Mr. ☐ Dr. ☐ Minor

Today's Date: _____

First Name: _____

Date of Birth: _____

Last Name: _____

Gender: ☐ Male ☐ Female

Address: _____

Social Security #: _____

City/Zip: _____

Preferred Phone: ☐ Home ☐ Cell ☐ Work

Occupation: _____

Home: _____

Employer: _____

Cell: _____

Marital Status: ☐ Single ☐ Married ☐ Other _____

Work: _____

Referred By: _____

Email: _____

Emergency Contact: _____ Emergency Phone: _____

Race: ☐ Hispanic/Latino ☐ American Indian or Alaska Native ☐ Caucasian

☐ Asian ☐ Black/African American ☐ Other _____

**VISION INSURANCE INFORMATION**

Name of Vision Insurance: ☐ VSP ☐ Eyemed ☐ MES ☐ Medicare ☐ Other_____

Policy Holder Name: _____ Policy Holder DOB: _____

**MEDICAL INSURANCE INFORMATION**

Name of Medical Insurance: _____ Member ID#: _____

Policy Holder Name: _____ Policy Holder DOB: _____

## DILATED RETINAL EXAM

Dilated eye exam is recommended to thoroughly evaluate your ocular health. Dilation drops enlarge the pupils to enhance the detection of ocular diseases. There is no additional fee for this exam. A $25 fee is applied if you choose to schedule a second appointment for dilation. Possible side effects include: inability to focus at near, sensitivity to light, blurred distance vision for some patients, mild burning upon instillation and in RARE cases induced ocular hypertension in which redness and sharp pain is experienced because of increased eye pressure. If this happens, contact the doctor immediately.

- ☐ I understand the above and consent to have dilation
- ☐ I understand the above and decline dilation at this time. I understand the potential for ocular diseases and loss of vision may exist, and without dilation, may go undetected.

**Signature:** _____ **Date:** _____

## ASSIGNMENT OF BENEIFTS AND FINANCIAL RESPONSIBILITY

I authorize the release of any medical information necessary to process this claim and request payment of medical benefits to be made directly to Stratford Eye Care Optometry, unless payment is made in full at time of service. I agree to bear full responsibility for co-pays, deductibles, non-covered and denied services by my insurance.

**Signature:** _____ **Date:** _____

**Relationship to Patient (If minor):** _____