NAME_____

**Dilated Health Examination** ***See disclaimer below**

Insurance recommends that your eyes be dilated as a part of the yearly eye health examination. Would you like Dr. Tallis to perform a dilated eye examination today?

___ Yes, I would **LIKE** to have a dilated eye examination and I understand the benefits as well as the risks of pupil dilation.

___ NO, I would **NOT** like to have a dilated health examination.

**Hobbies/Activities**: What do you like to do in your spare time?

1._____

2._____

3._____

**Estimated Daily Screen Usage** (Computer, Tablet, Smart Phone, TV ETC)

_____ HOURS

**If you are diabetic or have glaucoma, it is REQUIRED that you have a dilated exam. We are happy to schedule a time for you to come back for the dilated portion of your exam when it is more convenient for you.

**Text And Email Options**

We are implementing text and email reminders about appointments as well as glasses or contacts that are ready for pick up. Please indicate if you would like to receive office information in this manner.

____ YES

____ NO

Best contact phone number and email address

_____

_____

Is it ok to leave voice messages at your contact number regarding your personal information? _____ (Yes/No)

_____(Initial)

**Yearly HIPAA Initials**

I have been given the chance to read and or given a copy of the HIPAA guidelines and know that AVC will not release my medical information to anyone without my written consent._____(initial) I attest that the above information is true to the best of my knowledge, and give AVC permission to bill my insurance for services rendered._____ (Initial)

_____

**SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF PATIENT IS UNDER 18** **TODAY'S DATE**