WE THANK YOU FOR TAKING THE TIME TO COMPLETE THIS FORM AND FOR CHOOSING OPTIC GALLERY FOR YOUR VISION CARE.
Optic Gallery

Patient’s Name _____________________________________________ Date ____________________

Dilation of the Eyes

It will be necessary to dilate your pupils in order to perform a complete and thorough eye examination. This allows the doctor to obtain a better view of the back of your eyes. The dilating drops typically last 3-4 hours. During this time you may find it difficult to focus at near, and less commonly at distance. You may be sensitive to light. You will be provided with post-dilation sunglasses. We strongly recommend caution when driving or operating equipment or machinery after dilation. If you feel you would not be able to drive or return to work, we can reschedule the dilation portion of your exam. Signing in this section signifies that you have been informed of the risks and benefits of dilation.

Please select one of the options below, indicating your choice for dilation:

☐ I wish to have my eyes dilated today.

☐ I do not wish to have my eyes dilated and assume the responsibility of having an eye exam without dilation.

☐ I wish to have a dilation scheduled for another day

Signature (Patient or Guardian) __________________________________ Date _________________

Acknowledgement Notice of Privacy Practices

Signing in this section signifies that you have received a copy of our Notice of Privacy Practices

In the course of providing service to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for these services, and to conduct healthcare operations involving our offices. The Notice of Privacy Practices you have been given describes these uses and disclosures in detail.

Record Retention Policy

We are informing you that our office will keep your records for 5 years from the date of this examination. If signing for a minor, please be aware that our office will only keep your child’s records for 5 years from the date of this examination.

Signature (Patient or Guardian) _________________________________ Date _________________