



PATIENT INFORMATION SHEET

PATIENT'S NAME _____ (Mr. Mrs. Miss Ms.)
Last First Middle Initial

SOCIAL SECURITY NUMBER _____

MAILING ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHYSICAL ADDRESS: _____

DATE OF BIRTH: _____ () MALE () FEMALE () MARRIED () SINGLE

HOME PHONE _____ WORK PHONE _____

CELL PHONE _____ SPOUSE'S NAME _____

REFERRED BY _____

FAMILY PHYSICIAN _____

EMERGENCY CONTACT PERSON: _____ PHONE _____

PATIENT'S EMPLOYER: _____

EMPLOYER ADDRESS & PHONE: _____

IF YOU HAVE INSURANCE, WE WILL NEED TO COPY YOUR INSURANCE CARD. WE ARE UNABLE TO BILL YOUR INSURANCE WITHOUT A COPY OF YOUR CARD.

IF PATIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING:

GUARDIAN/PARENT'S NAME: _____

GUARDIAN/PARENT'S ADDRESS: _____

GUARDIAN/PARENT'S PHONE: _____

INFORMATION REGARDING DILATING DROPS:

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the doctor 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 doctor to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, you may need to wait for your eyes to adjust before driving or arrange for a driver. 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. By signing below I authorize Glacier Eye Clinic to administer dilating eye drops. I understand the eye drops are necessary to diagnose my condition.

RELEASE:

I affirm that the information I have given is correct to the best of my knowledge and that I am responsible to inform this office of any changes. I authorize Glacier Eye Clinic to administer dilating drops. I understand that I am responsible for all fees regardless of insurance benefits. I authorize the release of any medical information necessary to process my claims. I authorize the payment of medical benefits directly to the physician for services performed.

Signature _____

Date _____