

Patient Information

Name	Age	Birth Date	Today's Date
Address		Social Security #	
City		Home Phone #	
State	Zip	Work Phone #	
Guardian or Spouse		Employer	

Insurance Information

Insurance Carrier	Policy #				
Person responsible for bill					
Method of payment: Cash, Credit Card, Insurance					
<ul style="list-style-type: none"> ◆ For insurance purposes, I hereby authorize the release of any medical or other information necessary to process this claim and payment of medical benefits directly to Jeffery W. Williams OD & Associates P.A. ◆ I understand that I am financially responsible for charges not covered by insurance. ◆ Jeffery W. Williams OD & Associates P.A. has a comprehensive Notice of Privacy Practices that describes the use and disclosure of my information in detail. I understand these policies are posted at the front desk and are available as individual copies for my use. I authorize Jeffery W. Williams OD & Associates P.A. usage of my information as per the posted policies. 					
<i>Please Sign Here</i>					
Why did you choose Twin Lakes Eye Center? Circle one					
Yellow	Pages	Location	Insurance	Referral	Website
Other:					

Health History

What is your reason for seeking eyecare at this time?				
When was your last exam?	How old are your glasses?			
Where was your last exam?	Do you wear contacts?			
Do you or have you had any of the following? <i>Circle all that apply</i>				
Allergies	High blood pressure	Cataracts	Head Trauma	Flashes of light
Asthma	Diabetes	Glaucoma	Headaches	Floaters
Drug allergies	Cancer/Tumor	Color Blindness	Eye infection/Surgery	Eyeturn
Has anyone in your family had any of the following? If so, who?				
Y/N Diabetes	Y/N Retinal Disease	Y/N Cataracts		
Y/N Cancer	Y/N Glaucoma	Y/N Heart Disease/High Blood Pressure		
Are you presently under a physician's care? Y/N For what purpose?				
Are you currently taking medications? Y/N Please list:				
Are you pregnant? Y / N				
Are you a smoker? Y / N				

Dilation

To provide the most complete evaluation of your eyes, it is necessary to administer eye drops to dilate your pupils. With your pupils dilated, the doctor can better assess the health and condition of your eyes. There is no extra charge for this service. The doctor will discuss with you how the dilation might temporarily affect your vision. If you and the doctor agree that today is not a convenient time to have your eyes dilated, we will be happy to schedule a return visit at another time.

- _____ I hereby give my permission to have my eyes dilated.
 _____ I would like to schedule the dilation for another time.
 _____ I am undecided, and would like to discuss it with the doctor first.
 _____ I have read and understand the importance of having my eyes dilated, but refuse the procedure.

Patient or Guardian Signature _____ Date _____