

Patient Name: \_\_\_\_\_ Parents Name (if a child): \_\_\_\_\_

Address: \_\_\_\_\_ City/ZIP: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

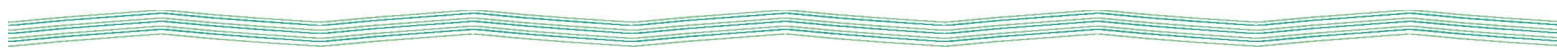
Email: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Occupation: \_\_\_\_\_

Referred By (*we would like to thank them*) \_\_\_\_\_ Is this your first time to this office?  YES  NO Male  Female  Single  Married  Widowed  Divorced  
**INSURANCE**Patient relationship to insured:  SELF  CHILD  DEPENDENT  SPOUSE

Social security #: \_\_\_\_\_ Employer: \_\_\_\_\_

Vision Plan: \_\_\_\_\_ ID#: \_\_\_\_\_

Medical Plan: \_\_\_\_\_ ID#: \_\_\_\_\_

  
**OCULAR & HEALTH HISTORY** (please list all active diagnosis for medical & ocular history): \_\_\_\_\_

Eye drops &amp; medications used: \_\_\_\_\_

Smoker?  YES  NO  IN THE PAST Pregnant?  YES  NO Contact lens wear?  YES  NO  INTERESTED  
Dear Patient,

We would like to take a photograph of the back of your eye (retina) using a special retinal camera. This procedure is not included in your regular eye exam. We feel however that it is important in analyzing the present health status of the eyes and monitoring it in future years. It is the easiest way to catch eye diseases early such as glaucoma or eye cancers. No eye drops are used for this procedure.

If ever an eye disease is found during a routine retinal photo, we will be able to bill it to your medical health insurance provider.

Please indicate if you would prefer routine photos for you or your child. The fee is \$10.00 total.

\_\_\_\_\_ **Yes**, I would prefer having routine retina photos taken \_\_\_\_\_ No, I elect to not have retinal photos taken

\_\_\_\_\_ I would like to discuss this procedure with the doctor

*I authorize the release of any medical or other information necessary to process my insurance claim. I also authorize payment of benefits to Jennifer Tabiza O.D. I understand that I will be financially responsible for payment of all charges, co-payments, and deductibles incurred for services rendered from this office:*

Signature of patient or guardian: \_\_\_\_\_ Date: \_\_\_\_\_