Contact Information & Dilation Questions:

Name:

Nick Name:

Date of Birth:

Address:

Home Phone:

Cell Phone:

Email:

Please read, initial, and sign below:

Dilation Policy: A **comprehensive yearly eye exam** includes a retinal examination to rule out breaks in the retina, blood vessel damage from diabetes and other systemic diseases, and retinal diseases such as macular degeneration. Dilation is routine and carries no extra cost.

___ **YES,** I consent to having dilating drops administered today. I understand dilation drops result in difficulty with reading/computer work AND light sensitivity, especially in sunlight, for the next **3-4** hours.
___**NO,** I decline having my eyes dilated today and, and agree to hold the practice harmless as a result.

Photos: Dr. Burgess recommends **Digital Retinal Screening** that allows for better detection, and documentation of potential eye disorders, such as glaucoma, macular degeneration, and diabetic macular edema.
The **fee for this procedure is $45** and is **not** covered by vision plans.

___**YES,** I agree to retinal photos today and I accept the $45 fee.
___**NO,** I do not want retinal photos today.

Contact Info:
___**YES**, I acknowledge the acceptance of receiving text messages from Valley Forge Eye Care and the biller regarding appointments, patient information, payments, and order updates.
___**NO**, I do not wish to receive text messages from Valley Forge Eye Care regarding appointments, patient information, and order updates.

In compliance with new industry policies, an electronic copy of your prescription will be uploaded to your HIPAA compliant patient portal directly after your exam with Dr. Burgess. Please sign below in acknowledgement of this new mandated policy

Date:_____ **Patient/GuardianSignature:**_____