

Questions??? Please read ENTIRE page then we'll happily answer any further questions.

VISUAL FIELD

A critical part of comprehensive eye care is a visual field. We highly recommend this test which gives a computerized examination of your side (peripheral) vision. Many diseases revealed by a visual field are undetectable in an eye examination and may only be diagnosed with a visual field. Some of the diseases that a visual field may detect are GLAUCOMA, retinal disease, BRAIN TUMORS, and many other disorders relating to the eye and brain.

The fee for this test is \$10.00. Your insurance will NOT cover this cost.

#1

- Yes, I give consent to have a visual field.
- No, I decline to have a visual field performed. I understand that this test helps in the detection of many diseases which can cause permanent and irreversible vision loss. I also decline this important part of my eye examination and release all doctors, personnel, and businesses associated with this facility from any liability related to the failure to detect and treat any condition in which the diagnosis would have been aided by this test.

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DILATION

We do not guarantee what you can or cannot do (INCLUDING DRIVING) while dilated. So please do not ask if you can drive because everyone is affected differently.

There are two main effects from pupil dilation. The first effect for 1 hour is decreased near vision the second effect is increased sensitivity to light for 4 hours. You are highly recommended to have your eyes dilated to rule out eye disease that may cause the loss of vision or worse. Dilation is an important part of finding and monitoring most eye diseases and a critical part of many other diseases (especially DIABETES). If you are diabetic please mark yes below.

#2

- Yes, I give consent to have my eyes dilated.
- No, I decline to have my eyes dilated. I understand this is an important part of my eye examination and release all doctors, personnel, and businesses associated with this facility from any liability related to the failure to detect and treat any condition in which the diagnosis would have been aided by this test.

Patient / Legal Guardian Signature: _____ Date: ____/____/____

#3 Please, please, please take a moment and tell us how you heard about us:

- radio, friend/family, phonebook, internet, doctor referred, newspaper, Walmart, other _____

- If friend/family above: Please tell us who REFERRED you so we can thank them _____

Give to receptionist when complete.

Office use only: Medical / Vision