Georgia Optometry Group Associates, PC

Dr. Gary Pence	Dr. Dale Anderson
Dr. Mary Brunner	Dr. Michael Richards
Dr. Kelly Spetalnick	Dr. Sharon Ellis

Our doctors have incorporated a computerized visual field analyzer into the practice that tests for loss of eyesight in your central and peripheral vision. This painless quick screening test can help the doctor in the detection of numerous health problems including Glaucoma, Diabetes, Stroke, Optic Nerve Disease, Retinal Detachment, Macular Degeneration and some brain tumors.

Your doctor recommends that all patients take this evaluation once per year, especially if there is a family history of these conditions or if you are having headaches or any other visual problems. This visual field analysis takes only a few minutes and there is an additional fee of $20.00.

_____ Yes, I would like the visual field screening test.

_____ No, I choose not to take the visual field screening test.

Signed_____Date_____

PUPIL DILATION WAIVER

In order to thoroughly examine the internal health of the eye, it is necessary to enlarge the pupil of the eye(dilation). This technique allows the doctor to observe the peripheral area of the retina that would otherwise be hidden from view. Many correctable problems can be detected this way. Dilation is accomplished through the use of eye drops.

The drops' effects may last from two to twelve hours. You may experience blurred vision for reading. Your distance vision will usually not be blurred but may seem a little distorted. The drops will also cause light sensitivity and you will be given a pair of sunglasses to wear to relieve this effect. You will be able to drive after dilation, but you should use extra caution. This applies to all physical activities, such as walking, climbing stairs or curbs, etc.

Complications from dilation are extremely rare. If you should experience any unusual pain or discomfort after dilation, you should call the office immediately. If the office is closed, call the emergency consultation number given.

You have the right to refuse dilation as well as any other medical procedure.

_____I hereby agree to have my eyes dilated.

_____I request not to have my eyes dilated.

Signed_____Date_____

Date:_____ Georgia Optometry Group

Patient History Form

Name_____M/F Date of Birth_____ Age_____

Address_____City_____Zip_____

Home Phone_____Cell_____Email_____

Occupation:_____Hours on Computer_____Hobbies_____

Insurance Information:

SSN(last 4 digits)_____Vision Insurance_____

Policy Holder's Name_____DOB_____Medical Ins._____

Date of last medical exam_____ Doctor's Name_____

Date of last vision exam_____ Doctor's Name_____

How did you hear about Georgia Optometry Group?_____

Reason for Visit: Glasses Evaluation_____Contact Evaluation_____Other_____

Please check any of the following that applies to you. If it applies to a family member, use the initials: M-Mother, F-Father, B-Brother, S-Sister, G-Grandparent, C-Children

General Health

___Diabetes ____Years
___High Cholesterol
___Thyroid Disease
___Headache/Migraine
___Asthma
___Seizures
___Anemia
___Immune Disorders
___Muscle/Joint Pain
___Diarrhea
___Fever
___HIV/AIDS

___High Blood Pressure ___Years
___Heart Disease
___Cancer _____Type
___Sinus Problems
___Respiratory Problems
___Psychiatric Problems
___Bleeding Problems
___Arthritis_____Type
___Genital/Urinary Problems
___Constipation
___Skin Irritations
Pregnant Y N

Eyes

___Glaucoma
___Cataracts
___Macular Degeneration
___Flashes/Floaters
___Eye Surgery
___Eye Injury
___Loss of Vision
___Glare/Light Sensitivity
___Lazy Eye Right Left
___Pain ___Watery
___Redness ___Itching ___Mucus
___Dryness ___Double Vision
___Sties ___Color Blindness

Current Medications

_____
_____
_____

List Allergies (Medical or Environmental)

_____
_____
_____

Reason For Visit_____

Glasses: Current Age of glasses_____ Any Complications?_____

Type(circle): Single Vision Bifocal Trifocal Progressive

Contact Lenses: Last fitting date_____ Any Complications?_____

Type (circle): Soft Disposable Soft Daily Wear Gas Permeable Extended Wear

Would you like to discuss (circle): Lasik Sport Eyewear Computer Eyewear Sun Protective Eyewear Contact Lenses

I have been notified of the availability of the Notice of Privacy Practices. Patient Initials_____Date_____

Signature_____Date_____