COPPERFIELD VISION
WELCOME BACK

DATE

GENERAL INFORMATION Home Phone_____ Work Phone _____
Cell
Phone_____
Mr., Mrs., Ms., Dr. _____ _____ _____
First Name of Patient M.I. Last Name of Patient

Address_____ Apt#_____ City/State/Zip_____

Occupation_____ Hobbies_____

Email Address_____ Vision Plan Company_____

EYE HISTORY
Purpose of today's visit_____

Do you want eyeglasses today? No_____ Yes_____ How many hours per day on the computer?_____

Do you want contact lenses today? No_____ Yes_____

MEDICAL / HEALTH HISTORY
Has your health changed since your last exam? No_____ Yes_____ Please explain_____

Are you pregnant? No_____ Yes_____

Known drug allergies_____

Are you currently under any medication? (Rx or OTC) No_____ Yes_____

Please list_____

Cancellation Policy for eyeglasses…Prescription lenses are custom orders. Although the entire process may take up to 2 weeks, the lenses begin being processed immediately. Because of this, there will be a 25% service charge for all cancelled orders for eyeglasses.
If your occupation or recreational activities expose you to the risk of flying objects or physical impacts, we recommend polycarbonate lenses for your protection.

Contact Lens…. For the health and safety of your eyes, we only prescribe daily disposable contact lens.

PUPIL DILATION…You must read and sign this section
Dilation of the pupil is considered standard procedure as part of a comprehensive eye examination. Dilating drops enlarge the size of the pupil (the central black spot of the eye) and allows the doctor a more thorough examination of the retina (the back part of the eye). Dilation assists in the detection of glaucoma, cataracts, diabetic and hypertensive retinal changes, retinal degenerative changes, retinal holes, tears and detachments, and some types of tumors. The side effects are light sensitivity while dilation lasts (4 to 6 hours) and trouble seeing up close (2 to 3 hours). It is possible, however unlikely, that dilation could precipitate a sudden rise in the eye pressure. If the doctor determines you are at risk, your pupils will not be dilated. You will usually be able to drive home. **We recommend that all patients receive an annual dilated exam.**

_____ _____
I agree to have my eyes dilated I do not want my eyes dilated

All insurance must be presented at the time of service. Patients are responsible for all fees. Any uncollected or denied claims from your insurance company are payable by the insured upon demand by this office. We do not bill for service, payment is due at time of service. We gladly accept your check as payment. However, in an effort not to inconvenience you, we reserve the right to electronically debit your account if this item comes back dishonored, plus a $30 (or legal limit) processing fee. Your signature is acceptance of this agreement and its terms.
I am an adult 18 years of age or older, or I am the parent/guardian of the minor child whose name appears above and hereby authorize Copperfield Vision to perform such eye care and treatment as it deems necessary or appropriate and consent to such care and treatment.

Signature of Responsible Party & Consent to Treat_____