# Patient Authorization for Services

Today's Date____/___/_____ _____ Date of Birth ____/___/_____

Last name First name Middle name/Initial **CIRCLE ALL THAT APPLY BELOW**

**Are you interested in**: Eye glasses Sun glasses Computer or Reading glasses

**Permission for the Contact Lens Exam/Fitting ($80-$150+), additional, elective & usually not covered by insurance.** Yes I want a Contact Lens Exam/Fitting.

No And I understand that I will not receive a contact lens prescription.

**We always keep a copy of your prescription(s) on file.**

Would like a copy of your eye glass prescription(s) Yes No

**Permission to Dilate**: Yes No I will discuss with doctor about dilation & photo.

**Permission for Retinal Photo ($30.00 and Recommended every 2 - 3 yrs.)**: Yes No

Responsible Party Signature _____ Date ___/___/____

***MEDICAL HISTORY / CONDITIONS / MEDICATIONS*** Please Check All That Apply

[ ] Respiratory [ ] Asthma [ ] Cardiovascular [ ] High Blood Pressure [ ] High Cholesterol [ ] Endocrine

[ ] Diabetes [ ] Thyroid Disease [ ] Hormone Replacement [ ] Immunologic [ ] Allergies [ ] Skin Condition

[ ] Neurologic [ ] Psychiatric [ ] Musculoskeletal [ ] Ears, Nose, Mouth, Throat [ ] Gastrointestinal

[ ] Genitourinary [ ] Blood Disease / Lymphatic Disease [ ] Significant loss or gain of weight in the last year

[ ] Recurrent fever within last year [ ] other _____

Please List your specific diagnosis(s) from above: _____

_____

_____

If Diabetic, Last Blood Sugar: _____ on ____/_____/_____ and Last a1c: _____on___/____/_____

List All Medications You Take: _____

_____

_____

_____

List All Medications You are Allergic to: _____

_____

List All EYE Disease, Injuries or Surgeries you have had: _____

_____

List immediate family member and their medical conditions: _____

_____

List immediate family member and their eye disease: _____

_____