Patient Welcome Form

General Information

Date: _____

First, Last, MI, Preferred Name _____

Street Address _____

City, State, Zip _____

Phone, Type _____

Phone 2 Type _____

Email _____

Preferred Contact Method Cell Phone Email Text Other (please explain) _____

Patient Social Security Number _____

Date of Birth _____

Male/Female _____

Occupation/Employer FT / PT _____

Marital Status Married Single Divorced Legally Separated Widowed _____

Language, Race, Ethnicity _____

Emergency Contact Person and Phone _____

Retinal Digital Imaging

We now offer state of the art retinal imaging. This provides permanent photodocumentation of your retina, optic nerve, and bloodvessels. This enables us to detect subtle findings in your retinal appearance and allows us to compare changes over time. This is an optional test which is highly recommended for all patients. We especially recommend it to those patients with diabetes, hypertension, headaches or a family history of retinal disease such as macular degeneration, glaucoma, or other eye conditions. It is also highly recommended for patients taking long term medications many of which have retinal/visual complications.

The fee for this test is $20.

Yes, I want the retinal photography.

No, I don't want the retinal photography