Georgia Optometry Group Associates, PC

Dr. Gary Pence	Dr. Dale Anderson
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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_____