Georgia Optometry Group Associates, PC

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

Computerized Visual Field Analyzer Waiver

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_____

Georgia Optometry Group Patient History Form

Date:_____

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

Have you had COVID-19? Yes or No

Current Medications

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

Eyes

___Glaucoma ___Cataracts
___Macular Degeneration ___Flashes/Floaters ___Eye Surgery

_____

List Allergies (Medical or Environmental)

_____

Pregnant

Yes or No

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

___Eye Injury
___Loss of Vision ___Glare/Light Sensitivity ___Lazy Eye Right Left
___Pain ___Watery ___Redness ___Itching ___Dryness ___Double Vision ___Sties ___Color Blindness
___Mucus

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

Signature_____Date_____

Georgia Optometry Group
Digital Retinal Photography Authorization

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Georgia Optometry Group is pleased to offer advanced digital retinal photography as an extension of your comprehensive eye examination.

The Topcon-TRC NW6 Nikon imaging system allows us to document permanent high definition retinal photographs for your medical records. This assists us in assessing the current health of your eyes as well as monitoring any retinal, optic nerve, macular and blood vessel changes over time. In most cases, the initial screening photo does not require the pupils to be dilated and can be done before seeing the doctor.

The doctors of Georgia Optometry Group recommend this procedure for all patients.

The fee for this part of the exam is $30.00. If it is determined that a more extensive photographic study is needed, the doctor will discuss this during your exam. Reasons for a more detailed study may include personal or family history of conditions such as Diabetes, Glaucoma, Macular Degeneration, elevated cholesterol or blood pressure, circulatory disorders, headaches, flashes and floaters, retinal bleeding or detachment, adverse effects of medication, sudden changes in vision, and/or trauma.

_____Yes, I want to have retinal photographs taken for documentation and evaluation.

_____No, I do not want to have retinal photographs taken for documentation and evaluation.

Signed_____Date_____