

Patient Registration Information

Please PRINT AND complete ALL sections below!

Patient's Personal Information	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Name: _____ <div style="display: flex; justify-content: space-between; font-size: small; margin-top: -10px;"> last name first name initial </div>				
Date of Birth: ____ / ____ / ____ Social Security #: ____ - ____ - ____				
Address: _____ Apt#: ____ City: _____ State: ____ Zip: ____				
Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____				
Email: _____				

Patient's / Responsible Party Information	Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____			
Name: _____ <div style="display: flex; justify-content: space-between; font-size: small; margin-top: -10px;"> last name first name initial </div>				
Date of Birth: ____ / ____ / ____ Social Security #: ____ - ____ - ____				
Address: _____ Apt#: ____ City: _____ State: ____ Zip: ____				
Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____				
Email: _____				

Emergency Contact
Name: _____ Relationship: _____
Address: _____ Apt#: ____ City: _____ State: ____ Zip: ____
Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____
Email: _____

PATIENT INFORMED CONSENT FOR / REFUSAL OF PUPIL DILATION

I understand the doctors of Arboretum Vision Care recommend it to more thoroughly evaluate the internal health of my eyes. Without dilation, serious eye diseases, such as diabetes, retinal detachment or malignant tumors (which can result in blindness, loss of an eye, or even death) could be present and not seen by the doctor. I understand there is not an alternative procedure that can replace dilation of my pupils. I agree to indemnify, hold harmless and waive and release from any and all claims, legal actions and attorney fees, which may arise as a result of my failure to comply with the instructions of my optometrist, Arboretum Vision Care and their employees, officers, directors and agents. I also understand that if my medical history warrants dilation, my doctor has the authority to insist on the procedure in order to continue with the examination.

Please check one: I agree to dilation today. I refuse the dilation.
 I will be responsible for rescheduling my dilation.

By emailing this forms packet, I understand that the act of emailing this information is equivalent to a signature on the document.

To email this document, first fill it out completely, then save it to your computer's hard disk and make note of the name of the saved file. Click the email link below, give your email a meaningful subject, such as "my contact info" and attach the completed, saved document and send.

Date: ____ / ____ / ____

Signature: _____