EYE FOUNDATION of UTAH

PATIENT INFORMATION

PLEASE PRINT CLEARLY

First Name_____

Last Name_____

Middle Initial_____ Marital status S M D W

Address_____

City_____

State_____ Zip Code_____

Email _____

Primary Phone (____)_____ cell wk hm

Secondary Phone (____)_____ cell wk hm

Sex: M F Birth date _____

Social Security # _____

Emergency Contact **NOT LIVING WITH YOU**:

Name _____

Relationship _____

Address_____

_____

Phone_____

Primary Insurance_____

Relation to Insured _____

Secondary Insurance _____

Relation to Insured _____

Occupation _____

Employer _____

City _____ State_____

Physician seeing today _____

Referring physician _____

How did you hear about us _____

Reason for today's visit

_____

In order to provide quality care we may communicate with your general care physician. If this is acceptable to you, please complete your physician's information below.

Primary care physician _____

Address _____

City _____ Ph _____

Pupil Dilation

As a part of your evaluation, pupil dilation is required to provide the doctor with an adequate view of the back of your eye. Dilation of the pupil may result in blurry vision after evaluation. It is not possible to predict how much your vision will be affected. While many patients feel comfortable to drive afterward, others may not feel secure in doing so. If you do not have a driver with you and DO NOT wish to be dilated, please notify the clinical staff prior to your examination and initial here _____.

_____ **Date** _____

Signature of patient/responsible party