WELCOME TO CALIFORNIA VISION AND VISAGE						Today's Date
In order to serve you properly, we will need the following information. (Please print.) All information will be strictly confidential						
PATIENT INFORMATION						
Legal Last Name	First	MI	AKA Name			
Social Security No.	Sex	Birth Date				
Residence Street Address	Apt	City	State	Zip	Country	
Day Phone ( )		Cell Phone ( )				
Preferred Language	Race	Ethnicity				
Email						
PERSON TO CONTACT IN CASE OF EMERGENCY						
Last Name	First	MI	Relationship			
Residence Street Address	Apt	City	State	Zip	Home Phone ( )	Business Phone ( )
PHARMACY INFORMATION						
Name		OR/ CONCOURSE RX PHARMACY			Phone	
Street Address		City	State	Zip	Fax ( )	

Assignment of Benefits: I hereby authorize the doctors of California Vision and Visage to furnish information to insurance carriers. I hereby irrevocably assign to the doctors of California Vision and Visage all payments for services rendered and all major medical benefits. I have read and understood Consents/Agreements: I hereby authorize my consent to be treated now and in the future by the doctors of California Vision and Visage.

x _____ _____

Patient (or person authorized to sign for patient) **Date**

INFORMATION REGARDING DILATING EYE DROPS

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye. Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it's best if you make arrangements not to drive yourself.

Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize Dr. Adam Hsu, Dr. Bonnie Woo and/or such assistants as may be designated by him or her to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

x _____ _____

Patient (or person authorized to sign for patient) **Date**