## **DILATION OF THE EYES**

Routine dilation of the eyes or eye drop induced widening of the pupil or black portion of the eye is a recommended health check for not only your eye health, but your physical health as well. It is part of our complete eye exam and there is no additional charge. If you are concerned with, or have a family history of any of the following, you are strongly urged to have your eyes dilated today:

Diabetes	High nearsightedness	Sudden Loss of Vision
Cataracts	Glaucoma	Macular Degeneration
Over the age of 60	High Blood Pressure	Frequent Headaches
Symptoms of flashes and/or	Brain Injury	Farsighted in Children
floaters		

## Once your eyes have been dilated, you may experience the following effects which may last 2 to 6 hours:

Undilated pupil

Portion of retina

Light beam

Retina

Optic

Before and After the Pupil Is Dilated

Dilated pupil

Portion of retina

Light beam

Retina

Optic

- 1. Increased sensitivity to light.
- 2. Mild blur of distance vision.
- 3. Inability to focus on near objects.

## Due to the above effects, we recommend that you have someone drive you home.

In most cases you can drive yourself. We also supply every dilated patient with disposable sunglasses. We request that you use caution and that you refrain from operating heavy equipment/machinery for at least 6 hours.

The doctor will be happy to answer any questions you may have!

Patient Signature:		Date:	/ /	
dilation.				
I do not wish to have my eyes dilated and	assume the responsibility of hav	ing my eye	s examined	without
I wish to have my dilation scheduled for a	nother day. (Please confirm with	front desk,	)	
I wish to have my eyes dilated today.				
Please check one:		Cour	tesy of the National Eye in	nstitute
	through undilated pupil.		ough dilated pupil.	

## **ACKNOWLEDGEMENT OF HIPAA & OFFICE POLICIES**

I acknowledged that I reviewed a copy of **Emerald City Eye Care's** HIPAA and office policies. I understand through this notice that my medical records will be retained in this office until further notice.

Patient Print Name: _			
Patient Signature:	Date:	_//_	