**Robert M. Allar, MD**
**Diseases of the Retina & Vitreous**

PATIENT NAME: _____
LAST FIRST M

ADDRESS: _____
STREET CITY STATE ZIP

PHONE: _____ WORK: _____
AREA CODE NUMBER AREA CODE NUMBER

CELL: ( ) _____ OTHER:_____

EMPLOYER: _____

DOB: _____ AGE: _____ SS# _____

REFERRED BY: _____
NAME PHONE

MEDICAL DOCTOR: _____
NAME PHONE

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**I understand that Dr. Allar will be using dilation drops for <u>all</u> my retinal examinations. Dr. Allar cannot perform a complete retinal examination without dilation. I am aware that my vision may be blurred for several hours which varies from person to person. Bright lights also may be bothersome after my examination. We have dark sunglasses if needed. I have been instructed prior to this appointment to make arrangements for someone to drive me or do so at my own risk.**

**I hereby authorize the administering of dilation drops for my examinations that will be done this year.**

**PATIENT SIGNATURE: _____ DATE:_____**

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Our office will file your insurance, but all co-pays and deductibles are due at the time of service. I understand that I am responsible for all fees, regardless of insurance coverage. I authorize the release of any medical information to process this claim and payment for medical and surgical benefits to Dr. Allar.

**PATIENT SIGNATURE: _____ DATE: _____**

METHOD OF PAYMENT: CASH:_____ CHECK:_____ MC/VIS:_____ HMO:_____ PPO: _____ MEDICARE: ____

Were you assisted in any way in the completion of this form? Yes:_____ No: _____

If yes, name of person who assisted you:
_____