Dr. Steven R. Koganovsky

Board Certified Optometric Physician

DILATED EXAMINATION CONSENT FORM

In order to perform a comprehensive eye examination, it is necessary to dilate the eyes. Even though almost forty percent of the posterior retina (back of your eye) can be viewed without d lation, sixty percent cannot be seen. Dilation is not necessary for determining your prescription f r glasses or contact lenses. Dilation simply enables the doctor to view a larger portion of the back of y our eye, and is doing so, allows the doctor to examine the peripheral retina for any holes, tears, etachments, tumors, or other peripheral retinal abnormalities which may not be seen without dilation.

Dilation requires three eye drops in each eye, as well as, 20-30 minutes for the dr ps to work. Your vision will become blurred for approximately 4-6 hours, especially near vision. Y ou will also experience light sensitivity for which we provide disposable sunglasses. If possible, i is strongly recommended that someone drive you home after the dilation.

PLEASE INITIAL YOUR PREFERENCE:

1. _____ I would like to have a complete, dilated examination.

2. _____ I would like a regular examination and decline the dilation.

I have read the above passage and know and understand the contents thereof as to necessity of dilation determining, detecting, and diagnosing disorders of the eyes. I understand by declining dilation I hereby remise, elease, acquit, satisfy and discharge the said releasee (Dr. Steven R. Koganovsky and associates) of and from all ac on or actions, cause and causes of action, suits, debts, damages, judgments, claims and demands whatsoever, which sai ' releasor ever had, now has, hereafter can, shall, or may have against said releasee. I sign this release voluntarily wit knowledge of its significance intending to be legally bound thereby.

Signature_____   Date_____