



TODAY'S VISION

THE ONE TO SEE®

**PLEASE CHECK ONE OF THE
FOLLOWING:**

_____ I consent to having an Advanced Retinal Imaging examination instead of dilation. (\$30.00)

**(ASK THE STAFF FOR MORE INFORMATION ON THE RETINAL
IMAGING)**

_____ I consent to dilation, acknowledge that my vision will be blurred, and decline Advanced Retinal Imaging examination.

Patient/Guardian Signature _____

Date _____