Mariana Toplek-Swartz, O.D. Brent P. Swartz, O.D.

SWARTZ
Family Eyecare LLC
"Focusing on your family with quality care"

DILATION POLICY

I understand that dilation of my pupils is an important diagnostic tool that aids the doctor in determining my state of health. I understand that by refusing dilation, I risk having a sight threatening disorder or other disease left undiagnosed.

PLEASE CHOOSE ONE OF THE FOLLOWING:

I allow Dr. Swartz to dilate my pupils today.

I am unable to have my pupils dilated today but am willing to return to do so.

I refuse dilation of my pupils today and will not be returning to do so.

I have had my eyes dilated within the last 6 months by Dr. _____.

_____ _____

Patient Signature **Date**

_____

Signature of Parent or Guardian (if patient under 18)