Optic Gallery

Date________________ Please Print First Visit (Y/N) _______

Patient's Name____ Sex (M/F)___ Age____ Date of Birth ___/___/___

Social Security # _______-_______-________ Email Address ________________________

If Married, Spouse's Name ________________________Spouse's S.S. # ____-____-____Spouse's D.O.B.___/___/___

If Child, Parent's Name________________________ Parent's S.S # _____-____-____Parent's D.O.B.___/___/___

Address____ City ______________State_______ Zip__________

Phone___________________ Cell _________________________ Business Phone ____________________

Place of Employment/School_______________________________ Occupation ________________________

Does your work require special vision needs? ________ If yes, please explain ________________________

Primary Insurance__________________ Insurance Phone # ____________ Vision Insurance_______________

Date of Last Exam_________________ Where_____________________ Doctor_____________________

Do you wear contact lenses? □Yes □No Type____________ Are you interested in wearing contact lenses? □Yes □No

Reason for Today's Visit____

List Activities/Hobbies____

How were you referred to our office? ____

MEDICAL HISTORY:

Medical Doctor ______________________________ Last Visit ____________

Do you have? □ **I Have No Medical Conditions** Do you: □Smoke □Drink □Use Drugs

□ Heart Disease □ Asthma □ Major Illness **Medications: □ None**________________

□ Diabetes □ Lung Disease □ Pregnant/Nursing ______________________________

□ High Blood Pressure □ Cancer □ Surgery __________ ______________________________

□ High Cholesterol □ Kidney Disease _______________ **Allergies: □ None** ______________

□Thyroid Problems □ Sinus Problems □ Other __________ ______________________________

□ Headaches □ Allergies _______________ ______________________________

Does Anyone in Your Family Have? □ **I Have No Family History of Medical Conditions**

□ Diabetes □ Cancer □ High Blood Pressure

□ Heart Disease □ Lung Disease □ Other____________________

OCULAR HISTORY:

Do you have? □ **I Have No Ocular Conditions**

□ Glaucoma □ Blurred Vision □ Eye Itching □ Eye Fatigue □ Dry Eyes

□ Cataracts □ Double Vision □ Eye Watering □ Eye Turn or Lazy Eye

□ Macular Degen. □ Flashes □ Eye Redness □ Eye Surgery (LASIK, PRK, etc.) _________

□ Blindness □ Floaters □ Eye Trauma □ Other Eye Disease ______________

Does Anyone in Your Family Have? □ **I Have No Family History of Ocular Conditions**

□ Glaucoma □ Blindness □ Macular Degen. □ Eye Disease □ Other__________

In the event that it becomes necessary for us to release your records to or request your records from another healthcare professional, I authorize Optic Gallery, and/or their associates to release and/or request these records. If applicable, I request that payment of authorized Medicare or other insurance be made either to me or on my behalf to Optic Gallery, and/or any of their associates for any services rendered to me. I authorize pertinent medical information about me to determine insurance benefits and billing to be released to the health care financing or other insurance agencies.

I UNDERSTAND I AM RESPONSIBLE FOR ANY CHARGES NOT COVERED BY MY INSURANCE COMPANY.

It is the policy of this office to require:

1) Payment in full or at least one-half before the order can be placed

2) The Balance of the fee must be paid at the time the order is dispensed

3) All orders are final when placed

SIGNATURE (Patient or Guardian):______________________________________**DATE**__________

WE THANK YOU FOR TAKING THE TIME TO COMPLETE THIS FORM AND FOR CHOOSING OPTIC GALLERY FOR YOUR VISION CARE.

Optic Gallery Fort Apache & Tropicana

Patient Privacy Notice Summary:

Earning and maintaining your trust and safeguarding your privacy is the cornerstone of our patient relationship with you. The protection of your privacy is a key part of maintaining your trust. This has been a fundamental operating principal of the Optic Gallery since our founding and remains so today. This Patient Privacy Notice Summary lets you know we maintain strict internal policies regarding confidentiality of patient information. We maintain physical, electronic, and procedural safeguards that comply with federal guidelines to safeguard patient information. Our employees are bound by our policies to access patient information only for legitimate clinical and/or business purposes and to keep such information confidential at all times. We pledge to do all we can to protect your privacy. If you have any questions about our Privacy Policy, or about how our information is maintained, safeguarded, or used, please contact our office, at (702) 586-5222. Signing this signifies you have received a copy and understand/agreed to our Notice of Privacy Practices.

SIGNATURE (Patient/Guardian)____ DATE______________

Medical Services Contact:

I hereby authorize and consent to medical treatment by the doctors of the Optic Gallery for myself (or my child). I authorize Optic Gallery to release my (or my child's) family doctor and to any other insurance company, adjuster, attorney agent working on behalf of Optic Gallery or other authorized party. I understand that I am responsible for payment of all vision and medical treatment rendered me (or my child) by Optic Gallery and I agree to pay all co-payment, deductibles, and non-covered services in full at the time of visit. I understand that, as a courtesy to me, Optic Gallery will file a claim with my (or my child's) insurance carrier, and I authorized payment directly to the Optic Gallery on Fort Apache for the benefits otherwise payable to me under the terms of my (or my child's) insurance. I understand that I am responsible for maintaining current coverage information to meet filing deadlines and for the payment of any remaining balance after payment from my insurance carrier.

SIGNATURE (Patient/Guardian)____ DATE______________

Dilation of the Eyes:

In order to perform a thorough and complete ocular exam, it is recommended to dilate your eyes. Dilation allows the doctors at Optic Gallery obtain a better view of the retina (a part behind the eyes). Diseases such as high blood pressure, diabetes, arthritis, auto-immune disorders, glaucoma, macular degeneration, and other conditions can affect ocular health and vision. Many medications, including vitamins, and foods can influence the health of your eyes and your vision. Dilation allows your doctor to examine the optic nerve, blood vessels, macula, and the extreme edges of the retain in detail.

Side effects of dilation include **blurry vision at distance and near and light sensitivity on average for 4-6 hours.** We strongly recommend caution when driving. Operating equipment or machinery after dilation is prohibited. Signing below signifies you have been informed of the risks and benefits of dilation; I understand having my eyes dilated will require a minimum 30 minutes or more during the examination.

Please select below your choice for dilation: (CIRCLE OR X)

- I **WISH TO HAVE MY EYES DILATED**
- I **DO NOT WISH TO HAVE MY EYES DILATED** AND I ASSUME THE RESPONSIBILITY OF HAVING AN EYE EXAM WITHOUT DILATION
- I **WISH TO RESCHEDULE MY DILATION**
- I **WISH TO DISCUSS** DILATION WITH DOCTOR

SIGNATURE (Patient/Guardian)____ DATE______________

Optic Gallery

Eye Wellness and Preventive Care

Retinal Scan & Retinal Photography

Sight threatening diseases such as **glaucoma, macular degeneration, diabetic retinopathy and hypertensive retinopathy** often have no outward signs or symptoms. A comprehensive examination, including a thorough retinal evaluation, is important to protect your vision. In an effort to provide a more advanced examination, Optic Gallery has incorporated **the iWellness exam which includes <u>Digital Retinal Photography</u>** (retinal photo of the back part of the eye) **and <u>Optical Coherence Tomography</u>** (CT scan of the back part of the eye).

The Doctor will review these highly advanced tests with you during your examination today. These two tests will become part of your permanent patient record. The iWellness exam establishes a baseline of your retinal health and allows the doctor to do a progressive analysis of your health every year. **<u>The cost of the iWellness examination is $49</u>, (unfortunately most vision and medical insurances do not cover this portion of the examination).** Any questions you have about these tests can be discussed during your examination with your Doctor.

iWellness exam is highly recommended for patients with these Diseases:

- **Diabetes**
- **Cataracts**
- **High Blood Pressure**
- **Frequent or Severe Headaches**
- **High Nearsightedness**
- **Symptoms of Flashes and/or Floaters**
- **Personal and/or Family History of Glaucoma**
- **Anyone over the age of 40**
- **Age Related Macular Degeneration (ARMD)**
- **History Retinal Diseases including Retinal Detachment**

PLEASE CHOOSE FROM THE FOLLOWING OPTIONS:

_____ **I WISH** to have the OCT (Optical Coherence Tomography) & DRP (Digital Retinal Photography)

_____ **I DO NOT WISH** to have the OCT (Optical Coherence Tomography) and DRP (Digital Retinal Photography)

_____ **I WISH to DISCUSS** the OCT (Optical Coherence Tomography) and DRP (Digital Retinal Photography) with the DOCTOR.

PATIENT SIGNATURE (PARENT/GUARDIAN) **DATE**

(IF PATIENT IS A MINOR 18 & UNDER; PARENT AND/OR GUARDIAN MUST SIGN)