

# 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 \_\_\_\_\_  
 Thyroid Problems  Sinus Problems  Other \_\_\_\_\_  
 Headaches  Allergies \_\_\_\_\_  
**Allergies:**  None \_\_\_\_\_  
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 retina 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 Digital Retinal Photography** (retinal photo of the back part of the eye) **and Optical Coherence Tomography** (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. **The cost of the iWellness examination is \$49, (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.

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PATIENT SIGNATURE (PARENT/GUARDIAN)

DATE

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



**Contact Lens Instruction for NEW / PREVIOUS Contact Lens Wearer**

- It is important to replace your lenses as often as prescribed.
- Report for regularly scheduled follow up care discussed with your doctor.
- Follow the wearing schedule prescribed by your doctor. Typically contact lenses can be worn 10-12 hours. NEW contact lenses wearers should start slowly. First day wear: 4-5 hours increasing wearing time ONLY 1 hour per day until reaching 10 hours.
- Always thoroughly wash, rinse, and dry your hands before handling your contact lenses.
- CLEAN your lenses daily after removal, as demonstrated, to avoid buildup of protein deposits and oily films.
- Use FRESH solution to RINSE and STORE your lenses for disinfection. Previous solution should be discarded.
- Generic solutions, such as Equate, is not the same as the recommended solutions.
- Rinse the contact lens case with warm water and let air dry when not between disinfection cycles.
- The contact lens case should be replaced **every 3 months** to reduce bacteria growth decreasing the risk of infection.
- AVOID aerosols or sprays. Apply cosmetics after inserting the lenses. Wear eye protection when in contact with harmful vapors or fumes, or in dusty environments.
- Keep a contact lens case and bottle of solutions with you in case you need to remove lenses immediately.

**The DON'Ts of Contact Lens use:**

- Never sleep in your contacts unless you are prescribed an extended wear contact lens by the doctor
- Never open your eyes while swimming in your contacts, or in the shower water
- Never use expired contact lenses or solutions
- Never use water or saliva with your lenses.
- Never use Rewetting Drops or Saline to store or disinfect lenses.
- Never use fingernails to remove lenses or while cleaning.
- Never wear a ripped contact lens.
- Never share your contact lenses.
- Never insert a lens into a red, irritated, or painful eye.
- Never use allergy drops, such as Visine, in your eyes while you are wearing contact lenses.

**SYMPTOMS OF EYE INFECTIONS INCLUDE (but not limited to):**

- \*Sudden blurred, fuzzy or cloudy vision
- \*Excessive Tearing
- \*Discharge OR Pain in or around the eye
- \*Increase light sensitive with or without lenses
- \*Red/irritated eyes lasting long period of time after insertion or removal

***Please call our office immediately if you are experiencing any of these symptoms (702) 586-5222***