**Dr. Mark J. Page, OD**
Optometrist/Orthokeratologist

**Dr. Alma D. Yamamoto, OD**
Optometrist/Orthokeratologist

**Dr. Kurt R. Jung, OD**
Optometrist/Orthokeratologist


**Patient Information:**

Patient's Name ______________________________________ Birth date _____________

Mailing Address ______________________________________________________________

_______________________________________________________________
(City) (State) (Zip Code)

Parent / Guardian ________________________________
(If patient is a minor)

Primary Phone # (_____)___________ Secondary/Work Phone # (_____)___________

E-mail address ________________________________ Occupation ________________

Employer or School (if patient is a student)_____________________________ Grade _____

How did you find out about our office? ___________________________________________

Insurance _____________________________ Policy Holder Name ____________________

Member ID # or SS # _________________________ Policy Holder Birth date ___________

I, __________________________________, am responsible for payment if my insurance company does not cover the services provided.
(signature of patient/guardian)

**Eye History:**

Date of last eye examination: ______________________ Doctor: ______________________

Do you currently wear glasses? Yes No Do you currently wear contacts? Yes No

Have you had any of the following?

| Condition | | |
|---|---|---|
| Strabismus (eye turn) | Yes | No |
| Amblyopia (lazy eye) | Yes | No |
| Keratoconus | Yes | No |
| Macular Degeneration | Yes | No |
| Glaucoma | Yes | No |
| Diabetic Retinopathy | Yes | No |
| Retinal Detachment | Yes | No |
| Retinal Disease | Yes | No |
| Optic Nerve Disease | Yes | No |

Other (please list)________________

Have you had eye surgery for any of the following?

| Surgery | | |
|---|---|---|
| Cataract | Yes | No |
| Trauma | Yes | No |
| Laser Vision Correction | Yes | No |
| Foreign Body Removal | Yes | No |
| Retinal Detachment | Yes | No |

Other (please list)________________________

Has anyone in your family had any of the following?

| Condition | | |
|---|---|---|
| Macular Degeneration | Yes | No |
| Glaucoma | Yes | No |
| Retinal Detachment | Yes | No |

**Medical History:**

Are you pregnant and/or nursing at this time? Yes No

Please list any medications you are taking (including eye drops & over-the counter)

_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

Are you allergic to any medications? Yes No If yes, please list

_____________________________________________________________________________

**Social History:**

Do you drive? Yes No If yes, do you have visual difficulty when driving? Yes No

Do you use tobacco products? Yes No If yes, type/amount/how long: __________________

Do you drink alcohol? Yes No If yes, type/amount/how long: _________________________

How did you hear about our office?________________________________________

If Someone referred you, please indicate name:_______________________________

May we use your name in thanking this person? Yes No

**Please complete** Date:____/____/_____

**Review of Systems:**

Do you currently, or have you ever had problems in the following areas?

| **Eyes (Ocular symptoms)** | **YES** | **NO** |
|---|---|---|
| Eye pain or soreness | ☐ | ☐ |
| Fatigue/tired eyes | ☐ | ☐ |
| Dry/gritty feeling | ☐ | ☐ |
| Redness | ☐ | ☐ |
| Burning | ☐ | ☐ |
| Itching | ☐ | ☐ |
| Excess watering | ☐ | ☐ |
| Mucous discharge | ☐ | ☐ |
| Chronic infections | ☐ | ☐ |
| Squinting | ☐ | ☐ |
| Glare/light sensitivity | ☐ | ☐ |
| Halos around lights | ☐ | ☐ |
| Double vision | ☐ | ☐ |
| Loss of vision | ☐ | ☐ |
| Blurred vision | ☐ | ☐ |
| Flashes | ☐ | ☐ |
| Floaters | ☐ | ☐ |
| **Constitutional** | | |
| Fever | ☐ | ☐ |
| Weight loss or gain | ☐ | ☐ |
| **Skin** | | |
| Rosacea | ☐ | ☐ |
| Metal allergies | ☐ | ☐ |
| **Ear, Nose, Throat, Mouth** | | |
| Allergies/hay fever | ☐ | ☐ |
| Sinus infections | ☐ | ☐ |
| Hearing Loss | ☐ | ☐ |
| **Respiratory** | | |
| Asthma | ☐ | ☐ |
| Chronic bronchitis | ☐ | ☐ |
| Emphysema | ☐ | ☐ |
| **Vascular/Cardiovascular** | | |
| Heart disease | ☐ | ☐ |
| High blood pressure | ☐ | ☐ |
| High cholesterol | ☐ | ☐ |
| Stroke | ☐ | ☐ |
| **Gastrointestinal** | | |
| Acid reflux | ☐ | ☐ |
| Intestinal problems | ☐ | ☐ |
| Liver/spleen problems | ☐ | ☐ |
| **Endocrine** | | |
| Thyroid/other glands | ☐ | ☐ |
| Diabetes | ☐ | ☐ |
| **Genitourinary** | | |
| Genitals/kidney/bladder | ☐ | ☐ |
| **Lymphatic/hematologic** | | |
| Anemia | ☐ | ☐ |
| Bleeding | ☐ | ☐ |
| **Bones/joints/muscles** | | |
| Rheumatoid arthritis | ☐ | ☐ |
| Muscle/joint pain | ☐ | ☐ |
| **Neurological** | | |
| Headaches | ☐ | ☐ |
| Seizures | ☐ | ☐ |
| Alzheimer's | ☐ | ☐ |
| Parkinson's | ☐ | ☐ |
| Multiple Sclerosis | ☐ | ☐ |
| **Cancer** | ☐ | ☐ |
| Type _______________ | | |
| **Psychiatric** | ☐ | ☐ |
| **Immune system** | ☐ | ☐ |

# Arizona's Vision

*In order to enhance, preserve and protect your eyesight for the rest of your life, please tell us a little about your lifestyle and your needs.*

**Name:** ______________________ **Date:** ________________

What brought you to our office today? ____________________________________________

Are you experiencing any vision problems? ____________________________________________

Occupation: ______________________________

Working Environment: Check ALL that apply

O In a retail store or restaurant
O Business or medical office
O Outdoors in landscaping, agriculture, or maintenance
O Outdoor construction site
O Indoor construction site
O Manufacturing shop floor
O Hospital
O School or College
O In an automobile
O On a boat or airplane
O From home
O Other ______________________

For each of the following activities, estimate how many hours you spend:

O At a Computer ______________hrs per week
O Watching TV ______________hrs per week
O Outside ______________hrs per week
O Riding in a vehicle (Daytime) ________hrs per week
O Riding in a vehicle (Nighttime)________ hrs per week
O Current Hobbies ______________hrs per week
O Reading ______________hrs per week
O On a mobile device ____________ hrs per week

These are activities I enjoy doing in my spare time:

| | | |
|---|---|---|
| O Computer | O Reading Books | O Running/Jogging |
| O Fishing | O Walking | O Woodwork/Carpentry |
| O Soccer | O Biking | O Camping/Hiking |
| O Tennis | O Sewing | O Baseball/Softball |
| O Football | O Basketball | O Playing musical instrument |
| O Movies/TV | O Hunting | O Skiing/Snowboarding |
| O Golf | O Swimming | O Skateboard/Scooter |
| O Playing cards | O Bowling | O Water Sports/Sailing/Jet Ski |
| O Travel | O Racquetball | O Shooting sports |
| O Gardening | O Home improvement/Repair | |
| O Cooking for fun | O Exercise Programs | |

O Other __________________________________

I am interested in the following:

O Checking if my prescription has changed
O Purchasing new glasses / contacts
O Information on new vision technology
O Information on Laser Vision Correction
O Better vision without surgery / glasses
O Preventing your child's vision from getting worse

For each of the following vision problems, indicate how frequently you experience the problem:

| | Frequently | Occasionally | Seldom/Never |
|---|---|---|---|
| Glare while driving at night | O | O | O |
| Tired eyes while working at a computer | O | O | O |
| Neck or back strain while working at a computer | O | O | O |
| Glare in sunlight or while working at a computer | O | O | O |
| Difficulty reading printed materials | O | O | O |
| Discomfort wearing glasses | O | O | O |
| Difficulty seeing the television clearly | O | O | O |
| Sensitivity to bright sunlight | O | O | O |
| Night vision difficulties | O | O | O |
| Watery or teary eyes | O | O | O |
| Red eyes | O | O | O |
| Dry eyes | O | O | O |

How do you feel about wearing glasses?

______________________________________

______________________________________

______________________________________

Are there any problems or questions about eyeglasses or contact lenses that you would like to discuss with the doctor or staff today?

Do you know that all eyeglass lenses are NOT the same? Quality of the lenses and optics can vary greatly.

# Acknowledgment of Receipt of Notice of Privacy Practices

**Arizona's Vision**
**Dr. Mark J. Page & Associates**
**15215 S 48th St. Suite 180**
**Phoenix, AZ 85044**

---

Patient Name: ______________________________________________

Patient Number: ____________________ Patient Phone Number: ____________________

Patient Address: ______________________________________________

***Signing this document signifies that you have received a copy of our Notice of Privacy Practices.***

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. The ***Notice of Privacy Practices*** you have been given describes these uses and disclosures in detail.

**I acknowledge that I have received the *Notice of Privacy Practices* from Arizona's Vision.**

______________________________________ ____________________
Signature Date

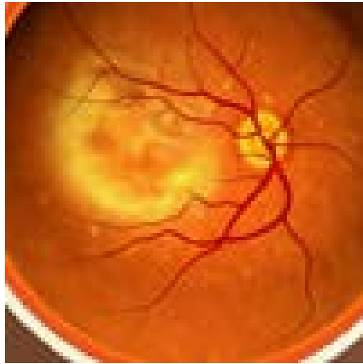
If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

______________________________ ______________________________
Relationship to Patient Print Name

Source of Authority: ______________________________________________

# Stop Blindness Before It Starts

Join the thousands of others who have used the Optomap to stop blindness before it starts. This is an image of the interior, back portion of the eye called the retina; and, for all intents and purposes, this area is responsible for capturing light and photo-chemically transferring the information to the area of the brain where vision takes place.



You can avoid the blurred vision of dilating drops *and* save 30 minutes today!

Macular Degeneration, Glaucoma, and Diabetes are the leading diseases causing blindness in the US today. To ensure peace of mind we will image your retina to determine your baseline interior eye health. Utilizing this technology, we can be proactive in maintaining your best eye health for your assurance and maintain an accurate historical record. Your fee is $29. The technician will perform this lightning fast and painless procedure during pretesting. **(A PORTION OF EACH OPTOMAP IS DONATED EVERY YEAR TO THE FOUNDATION FOR BLIND CHILDREN.)**

Accept (Sign):_______________________________________________

I decline Optomap and choose a dilation exam: (Initial)________

Date: ______________

# QuantifEYE®

Qualitative Understanding and Nutritional Treatment Intervention for the EYE

**To Our Patients,**

**Join the thousands of others who have used the Quantifeye to give an early detection of Macular Degeneration**. Recently, we acquired a device that allows us to assess your risk of developing an eye disease called Macular Degeneration. This disease is a leading cause of blindness in adults and there is no adequate treatment; however, it may be managed if caught early, with the use of dietary supplements and ultraviolet protection. We can now take measures to reduce your risk of developing this disease. The test is a light response test that only takes a few minutes. We now offer the screening to all patients 19 years and older, and develop a baseline measurement that allows us to track any changes that might occur in the future.

## Risk Factors *(please check all that apply)*

- ❑ **Age (over 50)**
- ❑ **Family History of:** ☐ Macular Degeneration, ☐ Glaucoma, ☐ Cataract, ☐ High Blood Pressure, ☐ Diabetes, ☐ Heart Disease
- ❑ **Smoker:** ☐ **Current** ☐ **Prior (when did you quit__________)**
- ❑ **If You have:** ☐ Glaucoma, ☐ Cataract, ☐ High Blood Pressure, ☐ Diabetes, ☐ Heart Disease
- ❑ **Do You experience:** ☐ Night Driving Difficulty ☐ Discomfort from Glare ☐ Sensitivity to bright light ☐ Difficulty seeing objects against their background ☐ Difficulty seeing close or near objects
- ❑ ☐ **Light colored eyes** ☐ **Caucasian** ☐ **Female**
- ❑ ☐ **< 6 servings of fruits & vegetables per day** ☐ **< 1 serving of cold water fish per week**

If you have two or more risk factors we strongly recommend that you take this test so we can assess your risk for Macular Degeneration, and develop a base-line measurement that allows us to track any changes that might occur in the future. Since this is a new test, never before available, it is not covered by your insurance. The cost to you will be $14.00. We feel it is well worth the cost as it may offer you additional protection against a very devastating disease. For a 6 month Quantifeye re-evaluation there is a $29.00 fee.

Should you have any questions, please do not hesitate to ask.

**(A PORTION OF EACH QUANTIFEYE IS DONATED EVERY YEAR TO A SCHOLARSHIP FUND TO HELP LOCAL AHWATUKEE HIGH SCHOOL SENIORS ATTEND COLLEGE, IN HONOR OF DR. PAGES'S MOTHER.)**

**I understand my risk factors for Macular Degeneration and choose to:**

❑ **ACCEPT TEST**

❑ **DECLINE TEST**

______________________________
Patient Signature

______________________________
Date

***For Office Use***

**Risk Assessment:**

**Doctor's Risk Determination**

| *(circle one)* | **High** | **Med** | **Low** |
|---|---|---|---|

**MPOD Score ___________ R/L**

| **<.25** | **.25 - .45** | **>.45** |
|---|---|---|
| **Lower Range** | **Mid-Range** | **Higher Range** |