optomap®
Retinal Exam

During a comprehensive eye exam our doctors monitor you for retinal complications including macular degeneration, glaucoma, and retinal holes or detachments. Arizona's Vision offers the latest optomap technology with OCT to detect these conditions.

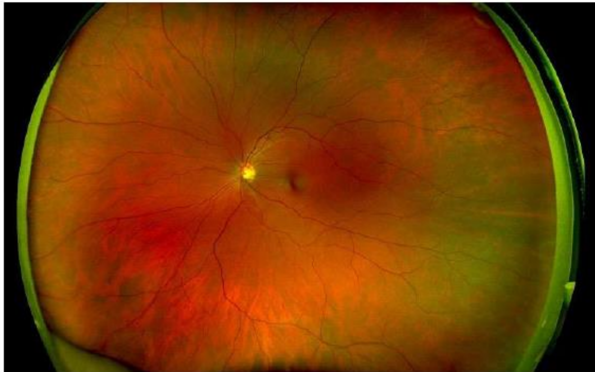
This screening procedure can also detect problems unrelated to the eye that may show early signs in the retina such as hypertension, cancer/tumors, auto-immune disorders, and others.

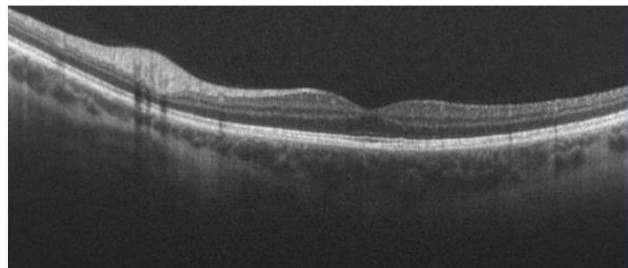
The new OCT technology allows us to scan all the layers of the retina to detect diseases such as macular degeneration or diabetic retinopathy earlier than possible with traditional methods.

The **Opto**map® Retinal Exam with OCT:

- ✓ Is the doctors preferred method of monitoring your eye and overall health
- ✓ DOES NOT REQUIRE DILATION DROPS
- ✓ allows your doctor to detect the presence of disease **early** in its progression
- ✓ will be saved in your medical file enabling your doctor to make important comparisons during your annual exams

The cost for these scans is $39, It is not covered by your insurance.





____ I understand that the **opto**map retinal exam will be performed today and do not have any questions.

____ I want to speak to the doctor for more information and understand that declining this procedure may limit the doctor's ability to optimally assess my ocular health.

Signature: ____

Admin use only: ☐ OCT ☐ Optomap ☐ MED ☐ AMA ______________________________

QuantifEYE®

ARIZONA'S VISION
SEE WHAT YOU'VE BEEN MISSING

Qualitative Understanding and Nutritional Treatment Intervention for the EYE

To Our Patients,

Join the thousands of others who have used 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 light response test only takes a few minutes. **We now offer the screening to all patients 19 years and older** to develop a baseline measurement that allows us to track any changes that might occur in the future.

Risk Factors *(please check all that apply)*

Family History of:

- ☐ Macular Degeneration
- ☐ Glaucoma
- ☐ Cataract
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Heart Disease

If You have:

- ☐ Glaucoma
- ☐ Cataract
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Heart Disease

Smoker:

- ☐ Current
- ☐ Prior
  When did you quit?________

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

Additional Factors:

- ☐ Age (Are you over 50?)
- ☐ Light colored eyes
- ☐ Caucasion
- ☐ 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.**

* In honor of Dr. Pages's mother, a portion of each QuantifEYE® examine is donated annually to a scholarship fund helping local Ahwatukee High School seniors attend college.

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

- ☐ ACCEPT TEST
- ☐ DECLINE TEST

____
Patient Signature

____
Date

For Office Use

Doctor's Risk Assessment:

(circle one)	High	Medium	Low

MPOD Score ______________________ R / L

< .25	.25 - .45	>.45
LOWER RANGE	MID-RANGE	HIGHER RANGE

15215 S. 48TH STREET | SUITE 180 | PHOENIX, AZ 85044

Understanding your contact lens care & fees

What are contact lens professional fees for? As a contact lens wearer additional tests are done for you that are necessary to make sure your eyes are healthy, that your lenses fit properly, and to ensure that you are seeing as well as possible. Contact lens professional fees are for the extra testing and time taken by the staff and doctor each year to properly evaluate your contact lenses and overall health of your eyes as it pertains to wearing contact lenses.

How much does it cost? Depending on the type of lenses you wear the cost for the professional services can vary. Costs for the contact lens evaluation **starts as low as $79.00 and can increase up to $250 for non-medically necessary fittings depending on the type of contacts prescribed and the complexity of your prescription.** The office staff will be able to give you the exact cost for the lenses that you wear and the professional services after you are finished with the doctor

Doesn't my insurance cover contact lens professional fees? It depends on your plan's coverage. Most insurance plans cover a routine eye exam which determines your glasses prescription and evaluates your eye health. Contact lens services are separate procedures that often are not covered by insurance but may be discounted pursuant to your insurance guidelines.

What type of additional tests are needed? Corneal topography is one example of a test done for contact lens wearers. With this computerized data we can detect any undesirable changes of the cornea caused by wearing contact lenses. A second test uses the microscope to examine the fit of the contact lens and the health of the cornea. Thirdly, prescription measurements are done which are different than those for glasses.

Isn't this part of my annual eye exam? These contact lens-related tests are done in addition to the eye examination. These procedures, that only need to be done for contact lens wearers, are not done for patients who don't wear contact lenses.

I have read and understand the purpose of the contact lens examination and accept the fees associated with wearing contact lenses.

PATIENT NAME: ____ **DATE:** _________________

PATIENT SIGNATURE (Parent/Guardian if under 18):___________________________________

ARIZONA'S VISION
SEE WHAT YOU'VE BEEN MISSING

Dr. Mark J. Page, OD
Optometrist/Orthokeratologist

Dr. Thomas Ulrich
Optometrist/Orthokeratologist

PATIENT INFORMATION:

Patient's Name ______________________ Birth date ______________

Mailing Address ____

City ______________________ State ________ Zip ____________

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: 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	**YES**	**NO**
Fever	☐	☐
Weight loss or gain	☐	☐
Skin	☐	☐
Rosacea	☐	☐
Metal allergies	☐	☐
Ear, Nose, Throat, Mouth	**YES**	**NO**
Allergies/hay fever	☐	☐
Sinus infections	☐	☐
Hearing Loss	☐	☐
Respiratory	**YES**	**NO**
Asthma	☐	☐
Chronic bronchitis	☐	☐
Emphysema	☐	☐
Vascular/Cardiovascular	**YES**	**NO**
Heart disease	☐	☐
High blood pressure	☐	☐
High cholesterol	☐	☐
Stroke	☐	☐
Gastrointestinal	**YES**	**NO**
Acid reflux	☐	☐
Intestinal problems	☐	☐
Liver/spleen problems	☐	☐
Endocrine	**YES**	**NO**
Thyroid/other glands	☐	☐
Diabetes	☐	☐
Genitourinary	**YES**	**NO**
Genitals/kidney/bladder	☐	☐
Lymphatic/hematologic	**YES**	**NO**
Anemia	☐	☐
Bleeding	☐	☐
Bones/joints/muscles	**YES**	**NO**
Rheumatoid arthritis	☐	☐
Muscle/joint pain	☐	☐
Neurological	**YES**	**NO**
Headaches	☐	☐
Seizures	☐	☐
Alzheimer's	☐	☐
Parkinson's	☐	☐
Multiple Sclerosis	☐	☐
Psychiatric	☐	☐
Immune system	☐	☐

Cancer (Type) ______________

DATE _____/_____/_______

15215 S. 48TH STREET | SUITE 180 | PHOENIX, AZ 85044

Acknowledgment of Receipt of Notice of Privacy Practices

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.

Patient Name: ________________________________ Date of Birth: ______________

Patient Signature: ____________________________________ Date: _____________

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

Relationship to Patient: ______________________ Source of Authority: _________________

Our patient's allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must sign this portion. Signing this form will only give information to family members indicated below.

I authorize Arizona's Vision to release my medical and/or billing information to the following individual(s):

1.______________________________ Relation to Patient: _____________________
2.______________________________ Relation to Patient: _____________________
3.______________________________ Relation to Patient: _____________________