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.

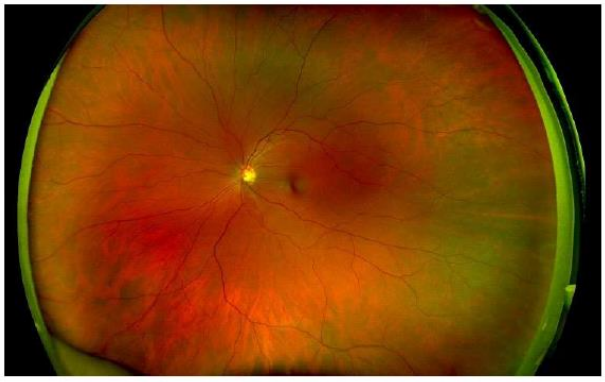
This screening procedure can also detect problems unrelated to the eye that may show early signs in the retina such as hypertension, cancer/tumors, auto-immune disorders, and others.

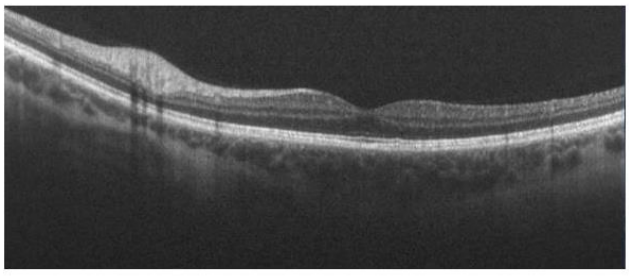
The new OCT technology allows us to scan all the layers of the retina to detect diseases such as macular degeneration or diabetic retinopathy earlier than possible with traditional methods.

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 _____

ARIZONA'S VISION
SEE WHAT YOU'VE BEEN MISSING

Child Patient Information

Patient's Name _____ Date of Birth _____

Address _____ Name used or Nickname _____

City _____ State _____ Zip _____

Home Phone _____ Preferred Phone _____

Email _____ Pediatrician _____

School Name _____ Grade _____

Father's Name _____ Date of Birth _____

Employer _____ Work/Cell Phone _____

Mother's Name _____ Date of Birth _____

Employer _____ Work/Cell Phone _____

Is your child having any problems in school with: *(please check all that apply)*

☐ Reading ☐ Writing ☐ Math ☐ Other _____

Has your child ever had a problem:

☐ Recognizing colors
☐ Recognizing numbers
☐ Recognizing letters
☐ Letter/Word Reversals
☐ Eye strain while reading
☐ Eye Rubbing while reading
☐ Headaches while reading
☐ Reading Comprehension

Special class for any subject:

Yes No Which ones?

_____

_____

Repeated grade _____

Has your child:

☐ Ever Been Patched
☐ Wear: Glasses
☐ Wear: Contacts
☐ Problem with an eye turn
☐ Covered an eye while reading

Is there anything else we should know about your child?

_____

_____

_____

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

ARIZONA'S VISION
SEE WHAT YOU'VE BEEN MISSING

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: _____