



Date: \_\_\_/\_\_\_/\_\_\_

**Patient Information:**

Patient's Name \_\_\_\_\_ Birth date \_\_\_\_\_

Mailing Address \_\_\_\_\_

(City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip Code) \_\_\_\_\_

Parent / Guardian \_\_\_\_\_  
(If patient is a minor)

Home Phone # (\_\_\_\_) \_\_\_\_\_ Work/Cell 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  
(signature) company does not cover the services provided.

**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**

- 

**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?      Have you had eye surgery for any of the following?

- |                                   |                                     |
|-----------------------------------|-------------------------------------|
| Strabismus (eye turn)      Yes No | Cataract      Yes No                |
| Amblyopia (lazy eye)      Yes No  | Trauma      Yes No                  |
| Keratoconus      Yes No           | Laser Vision Correction      Yes No |
| Macular Degeneration      Yes No  | Foreign Body Removal      Yes No    |
| Glaucoma      Yes No              | Retinal Detachment      Yes No      |
| Diabetic Retinopathy      Yes No  | Other (please list) _____           |
| Retinal Detachment      Yes No    |                                     |
| Retinal Disease      Yes No       |                                     |

Has anyone in your family had any of the following?

- |                                 |                                  |
|---------------------------------|----------------------------------|
| Optic Nerve Disease      Yes No | Macular Degeneration      Yes No |
| Other (please list) _____       | 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 so, 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 \_\_\_

# Your Vision And Lifestyle

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Please take a moment to complete this questionnaire so we can better understand your daily vision needs.

## Occupation

What is your occupation? \_\_\_\_\_

How many hours do you spend reading on a daily basis? \_\_\_\_\_

How many hours on average do you spend working on a computer on a daily basis? \_\_\_\_\_

Do you work in: (check one)       Bright light  
    Medium light  
    Low light

Do your eyes feel tired or strained at the end of the workday?      Yes \_\_\_      No \_\_\_

## Recreation

Do you participate in any contact sports?      Yes \_\_\_      No \_\_\_

Do you wear sunglasses with UV protection      Yes \_\_\_      No \_\_\_

Does driving at night bother you?      Yes \_\_\_      No \_\_\_

Indicate which, if any, of the following activities you participate in:

<input type="checkbox"/> Tennis	<input type="checkbox"/> Hunting
<input type="checkbox"/> Contact Sports	<input type="checkbox"/> Scuba Diving
<input type="checkbox"/> Racquetball	<input type="checkbox"/> Golf
<input type="checkbox"/> Jogging/Walking	<input type="checkbox"/> Drawing/Painting
<input type="checkbox"/> Boating	<input type="checkbox"/> Needlework
<input type="checkbox"/> Snow Skiing	<input type="checkbox"/> Woodwork/Furniture Refinishing
<input type="checkbox"/> Fishing	_____ Other (please list)

## General

Have you ever wanted the ability to see clearly without wearing glasses or contacts and **without** surgery?      Yes \_\_\_      No \_\_\_

Would you be interested in a contact lens worn while sleeping, and in the morning once you remove it, you can see clearly for all of your waking hours without glasses and contacts?  
Not interested \_\_\_      Somewhat interested \_\_\_      Very interested \_\_\_

Are you interested in Laser Vision Correction?  
Not interested \_\_\_      Somewhat interested \_\_\_      Very interested \_\_\_

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**Your vision is our primary concern. If you have any questions, please don't hesitate to speak with any one of our staff members.**



**IMPORTANT ANNOUNCEMENT FROM DR. PAGE AND ASSOCIATES**

Arizona's Vision is proud to provide our patients with the most highly advanced technology available in retinal screening today! Our ability to view your internal retinal health is now dramatically improved with the Optomap.

Dr. Page and Associates are concerned about retinal problems such as macular degeneration, glaucoma, retinal holes or detachments and diabetic retinopathy (all of which can lead to partial loss of vision or blindness). Additionally, systemic diseases such as diabetes and high blood pressure can be detected during a retinal exam.

**EARLY DETECTION IS CRUCIAL!!**

**What would happen to you or your family if you lost your eyesight?**

Optomap Provides:

- An annual eye wellness scan
- An in depth view of the retinal layers (where disease can start).
- The ability to show you your images today during your exam.
- A permanent record for your medical file, which gives your doctor comparisons for tracking and diagnosing potential eye disease.

Optomap:

- Is fast, easy, and comfortable.
- **Will NOT require dilating drops (which result in blurred vision and sensitivity to light).**

Your vision insurance does not cover advanced testing like Optomap. The doctors at ARIZONA'S VISION would like for ALL of their patients to have an Optomap exam annually. The additional fee is only \$29.

\_\_\_ I elect to have an Optomap of my retina.

\_\_\_ I prefer to have a dilated exam **TODAY** instead of the Optomap. I understand that it will take an additional 30 to 45 minutes and I will experience blurred vision and light sensitivity for 4 to 6 hours.

\_\_\_ I prefer to schedule a dilated exam for another day. I understand that there will be a fee of \$39 for a separate office visit.

\_\_\_ I have chosen not to have either service performed, and will not hold Dr. Page and associates and/or his staff responsible for any disease or pathology that goes undetected due to lack of diagnostic information that could have been obtained through the Optomap or dilated exam.

\_\_\_\_\_  
Patient(or parent/guardian) signature

\_\_\_\_\_  
Date

# QuantifEYE

## Qualitative Understanding and Nutritional Treatment Intervention for the EYE

### To Our Patients,

We continuously strive to provide our patients the very best in eye care services. 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 screen 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: \_\_\_\_\_
- Family History of:  Macular Degeneration,  Glaucoma,  Cataract,  High Blood Pressure,  Diabetes,  Heart Disease
- Smoker (even if you have quit)
- If You have:  Glaucoma,  Cataract,  High Blood Pressure,  Diabetes,  Heart Disease
- Sensitive to light
- Excessive exposure to the sun
- Female
- Light eyes, light skin
- Inadequate consumption of green, leafy vegetables

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 \$10.00. We feel its well worth the cost as it may offer you additional protection against a very devastating disease.

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

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			
<i>(circle one)</i>	High	Med	Low
MPOD Score			R/L
<.25	.25 - .45		>.45
Lower Range	Mid Range		Higher Range

# Acknowledgment of Receipt of Notice of Privacy Practices

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

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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: \_\_\_\_\_