CHILD'S PATIENT INFORMATION

Date ________________ Date of Birth ________________

Patient's Name ________________ Name used or nickname ________________

Address ________________ Home Phone ________________

City ________________ State ________ Zip ________

School ________________ Phone ( ) ________________

Grade ________________ Teacher's Name ________________

Father's Name ________________

Employer ________________ Business Phone ( ) ________________

Business Address ________________

City ________________ State ________ Zip ________

Mother's Name ________________

Employer ________________ Business Phone ( ) ________________

Business Address ________________

City ________________ State ________ Zip ________

Whom may we thank for referring you to this office? Name: ________________

________ Family ________ Friend ________ Phone Book ________ Other, explain ________________

1. Are you having any problems in school with:

   Reading ________ Writing ________ Math ________ Other ________________

2. Are you usually seated: Toward the Front ________ Middle ________ Back ________

3. Do you blink or rub your eyes often? Yes______ No______

4. Do you have:

   Headaches ______ Nausea ______ Dizziness ______ Restlessness ______

   Itching ______ Burning ______ Blurred or Double Vision ______

5. Do you read with your head close to book? Yes______ No______

Please check the method of payment for today's professional services:

____ Cash ____ Check ____ Credit Card ____ Insurance

________________________ ________________________

Signature of Party Responsible for Payment Relationship

Your Vision And Lifestyle

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:

___Tennis
___Contact Sports
___Racquetball
___Jogging/Walking
___Boating
___Snow Skiing
___Fishing
___Hunting
___Scuba Diving
___Golf
___Drawing/Painting
___Needlework
___Woodwork/Furniture Refinishing
____________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___

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

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: ______________________________