



WELCOME TO OUR OFFICE

Today's Date: Date of Last Exam:

PATIENT INFORMATION

Check one: Mr Mrs Miss Dr
 Last _____
 First _____
 Street _____
 City _____ State _____
 Zip Code _____
 Home Phone _____
 Work Phone _____
 Cell Phone _____
 Date of Birth _____ Age _____
 Social Security # _____
 Sex M F
 Nursing? Y N Pregnant? Y N

PATIENT/PARENT EMAIL

Employer or School _____
 Occupation or Grade _____
VERY IMPORTANT!! NEW PATIENTS ONLY:
 Who may we thank for referring you to our office?
 Name of friend or relative _____
 If not referred, how did you choose our office?
 Another Dr.
 Insurance List
 Saw Sign/Building
 Newspaper/Magazine
 Yellow Pages: Which Directory? _____
 Other _____

REASON FOR TODAY'S VISIT

What is the reason for this visit?

 Any problems with your current contact lenses or glasses? _____

PATIENT MEDICAL HISTORY

Family Physician _____
 Date of Last Physical Exam _____
 Please list all medications (including ocular) you are currently taking: _____

 List any allergies to medications or food: _____

 Do you smoke? Yes No
 Do you drink alcohol? Yes No

LIFESTYLE QUESTIONS

Do you...(check box if your answer is yes)
 Work at a computer?
 Spend time outdoors? How much? _____ Hrs/Wk
 Prefer not to wear your glasses at times?
 Have prescription sunwear?
 Have an interest in vision therapy?

INSURANCE INFORMATION

Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company...not Carlsson Family Eye Center.
 Vision Insurance _____
 Subscriber Name _____
 Subscriber SSN or ID # _____
 Subscriber Birth Date _____

 Primary Medical Insurance _____
 Subscriber same as above.
 Subscriber Name _____
 Subscriber SSN or ID # _____
 Subscriber Birth Date _____
 Do you participate in a flex spending account?
 Yes No

OCULAR HISTORY

Have you and/or a family member ever experienced; been diagnosed or treated for any of the following:

	Self	Relation To Patient
<input type="checkbox"/> Amblyopia (Lazy Eye)		
<input type="checkbox"/> Blindness		
<input type="checkbox"/> Cataracts		
<input type="checkbox"/> Crossed Eye		
<input type="checkbox"/> Eye Injury		
<input type="checkbox"/> Eye Surgery		
<input type="checkbox"/> Glaucoma		
<input type="checkbox"/> Macular Degeneration		
<input type="checkbox"/> Other Ocular Disease		
<input type="checkbox"/> Recurrent Eye Infec./Ulcer		
<input type="checkbox"/> Retinal Detachment		
<input type="checkbox"/> Retinal Disease		
<input type="checkbox"/> Retinal Tear/Hole		
<input type="checkbox"/> Strabismus (Eye Turn)		

GENERAL HEALTH

Have you and/or family member ever experienced; been diagnosed or treated for any of the following:

	Self	Relation To Patient
<input type="checkbox"/> Allergies		
<input type="checkbox"/> High Blood Pressure		
<input type="checkbox"/> Heart Problems		
<input type="checkbox"/> High Cholesterol		
<input type="checkbox"/> Diabetes		
<input type="checkbox"/> Thyroid Problems		
<input type="checkbox"/> HIV/STD		
<input type="checkbox"/> Sickle Cell Disease		
<input type="checkbox"/> Lupus		
<input type="checkbox"/> Multiple Sclerosis		
<input type="checkbox"/> Skin Condition		
<input type="checkbox"/> Arthritis		
<input type="checkbox"/> Migraines		
<input type="checkbox"/> Cancer/Tumor		
<input type="checkbox"/> Asthma		

PATIENT BIRTH AND DEVELOPMENT HISTORY

To the Parent or Guardian: Information about your child's general health and development is essential in our care of your child. Please complete the questions that follow:

Patients name: _____ School Name: _____

Grade Level: _____ Form completed by: _____

Relationship to child: _____

- | | | |
|--|-----------|----------|
| Has this child been adopted? | _____ Yes | _____ No |
| Does the child have a hearing problem? | _____ Yes | _____ No |
| Does the child have a speech problem? | _____ Yes | _____ No |
| Is there a problem with attention or discipline? | _____ Yes | _____ No |

Has the child ever received the following services?

Speech therapy _____ Yes _____ No If yes, please explain _____

Occupational therapy _____ Yes _____ No If yes, please explain _____

Physical therapy _____ Yes _____ No If yes, please explain _____

Developmental therapy _____ Yes _____ No If yes, please explain _____

EDUCATION

Education: Please check any of the following that are TRUE about your child's performance:

- School suggests testing to rule out vision problems causing academic problems.
- Errors in copying from blackboard to paper.
- Avoids near work (reading/writing) or fails to complete work in allotted time.
- Poor reading comprehension.
- Reads below grade level.
- Tilts or turns head excessively during visual tasks.
- School performance not up to potential.
- Poor handwriting/printing.
- Poor spelling ability.
- Reverses letters when reading or writing.

PERFORMANCE

When reading, does the child:

- Confuse similar words.
- Use finger or marker to keep place.
- Often lose place, skip or reread words or letters.
- Complain of blurred vision
- Complain of headaches.
- Complain of print "running together" or "moving around"
- Says eyes hurt, burn or tire

Has the child had special education testing or received tutoring services? _____ Yes _____ No

Has the child had an IEP (individual education plan) established? _____ Yes _____ No

Best school subject: _____

Worst school subject: _____

Have there been consultations with doctors or specialists (i.e., neurologists, psychologists) with reference to schoolwork?
 _____ Yes _____ No

If yes, please discuss _____

Have any other family members had academic or school-related problems? _____ Yes _____ No

If yes, please discuss _____



VIRTUALLY ALL OF THE MAJOR CAUSES OF BLINDNESS CAN BE DETECTED BY CHANGES IN THE VISUAL FIELD & THROUGH DILATION

VISUAL FIELD SCREENING *FOR 10 & OLDER

The new OCTOPUS 301 VISUAL FIELD is a highly sophisticated instrument that can electronically measure the retinal function and sensitivity to light. The Visual Field Analyzer can detect diseases such as pituitary tumors, glaucoma, retinal or macular degeneration, optic nerve disease, or retinal disturbances due to vascular problems or medications and many other conditions that manifest itself in the eye.

The doctor strongly recommends that all patients (ten and older) receive the visual field screening. It is especially important for people who have:

- Headaches
- Flashes of light
- A history of diabetes
- High Blood Pressure
- Heart problems and/or circulatory problems
- A strong eyeglass prescription

There is an **additional charge of \$15.00** for the screening. This is not a procedure that insurance will pay for and therefore the patient accepts the responsibility and liability for the charge. This procedure has no side effects and will require an additional 10 minutes of your time.

_____ Yes, I would like the Visual Screening at this time.

_____ No, I would not like the Visual Screening at this time.

(Patient/Guardian)

Date

DILATION WAIVER

To do dilation means the doctor uses eye drops to temporarily enlarge your pupils (dilated fundus evaluation). Without dilation, the doctor can only see about 20% of the inside of your eye. With dilation, the doctor can see problems that you cannot feel or see until your vision is impaired. All new patients, **especially children 10 and younger**, need to be dilated in order for the doctor to thoroughly assess the health of the eye. Additionally, children need to be dilated in order to determine a child's "true" prescription.

**This procedure will leave you light sensitive with blurry near vision for approximately 4-6 hours. You will be able to drive but please be more careful if doing so.

** Dilation is **not** recommended for patients who are: pregnant, nursing and/or with neurological disorders.

_____ Yes, I would like the Dilation at this time.

_____ No, I would not like the Dilation at this time.

(Patient/Guardian)

Date



CONTACT LENS FITTING & EVALUATION*

*This is only for the individual who would like to be fitted for contact lenses.

Contact lenses are medical devices, regulated by the FDA. This means that the doctor has to evaluate the health of your eyes and the fit of your contacts every year in order to determine the optimum prescription for your eyes. Contact lens examinations are required on a yearly basis. These tests are done to make sure your eyes are healthy, that the lenses fit your eyes properly, and to ensure that you are seeing as clearly as possible.

All contact lens patients will be charged a contact lens fitting and evaluation fee. The fee varies based upon the type of contact lens, doctor/staff time involved and expertise necessary. **Insurance companies require that we bill contact lens fitting/evaluation charges separately from your comprehensive eye examinations.** In most cases, insurance companies consider contact lenses "not necessary" and they will not cover these charges. The services received for this fee include the fitting/refitting and evaluation for contact lenses, tear film/corneal health analysis, all contact lens follow-up visits with the doctor for 60 days, any diagnostic lenses used, a contact lens starter solution kit, and a class to teach you how to properly care for your contacts if necessary. There are typically rebates and discounts available when buying a year supply of contacts, feel free to inquire about them.

Contact Lens Evaluation: The contact lens evaluation is not part of the standard eye exam. There is an additional fee for a contact lens evaluation/fitting and contact lens prescription update. **These fees are determined based on the type of lenses you are fit with and need to be paid at the time of your copy.**

Soft Spherical	\$79.00
Soft Toric	\$94.00
Soft Monovision/Early Presbyopia	\$99.00
Monovision	\$99.00
Soft Multi-focal	\$129.00
Soft Multi-focal Toric	\$139.00
RGP Spherical	\$139.00
RGP Toric	\$149.00
RGP Multi-focal	\$159.00
Specialty Kone Fit	\$349.00
Specialty Fit	To be determined by the doctor.

Signature _____ Date _____



NOTICE OF PRIVACY PRACTICES

To our patients. This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to *Carlsson Family Eye Center, 3592 S. Atherton Blvd., Ste. 111, Gilbert, AZ 85297. There will be a copying fee based on the number of pages.*
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to *Carlsson Family Eye Center, 3592 S. Atherton Blvd., Ste. 111, Gilbert, AZ 85297.* You must provide us with a reason that supports your request for amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact *Carlsson Family Eye Center, 3592 S. Atherton Blvd., Ste. 111, Gilbert, AZ 85297.* All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact *Carlsson Family Eye Center, 3592 S. Atherton Blvd., Ste. 111, Gilbert, AZ 85297, 480-988-4131.*

Please retain this copy for your own personal use.

VISUAL FIELD SCREENING

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It is especially important for people who have:

- Headaches
- Flashes of light
- A history of diabetes
- High Blood Pressure
- Heart problems and/or circulatory problems
- A strong eyeglass prescription
- Sudden change in vision

There is an **additional charge of \$15.00** for the screening. This is not a procedure that insurance will pay for and therefore the patient accepts the responsibility and liability for the charge. This procedure has no side effects and will require an additional 10 minutes of your time.

_____ Yes, I would like the Visual Screening at this time.

_____ No, I would not like the Visual Screening at this time.

Signature _____

DIGITAL RETINAL SCREENING

The retinal screening is a test Dr. Carlsson highly recommends for **all** patients. He intended to use it primarily for tracking his diabetic, glaucoma, and macular degeneration patients, but the doctor feels strongly that it is important to have a baseline study on every patient. This would be extremely helpful should a condition develop in the future. The study can also reveal many developing health conditions sooner than conventional testing. **This baseline procedure is \$35.00.**

Your insurance will not ordinarily cover the cost of the screening, but if Dr. Carlsson discovers a medical condition as a result of the study, we may bill your medical insurance. This would entail a follow up medical appointment with additional photos and interpretations of his findings. If your insurance does not cover the billed amount or your deductible has not yet been met, you will be billed the amount of the screening which would be \$35.00.

_____ Yes, I would like the photos taken at a cost of \$35.00

_____ No, thanks

_____ I need more information

- I want to discuss with the doctor first
- See if I qualify to have my insurance billed

_____ I agree, to have both screenings done for a reduced fee of **\$45.00.**

Date _____