Welcome back to our office! Please provide us with any changes to the following information:

LAST NAME_____ FIRST NAME_____

ADDRESS_____ DATE OF BIRTH _____

CITY/STATE_____ ZIP_____ AGE_____

HOME/CELL PHONE_____ WORK PHONE_____

EMAIL_____ OCCUPATION_____

FAMILY PHYSICIAN_____ PHYSICIAN'S PHONE_____

HAVE YOU CHANGED YOUR VISION INSURANCE? Yes No *If yes, please complete a new Insurance Form.*

Medical History *This information is kept strictly confidential*

Please list any Medical Conditions for which you are currently being treated for:

_____

_____

_____

Currently Pregnant or Nursing ❒

Tobacco Use Former ❒

Tobacco Use Current ❒

Please list any Medications you are currently taking (include over-the-counter, vitamins or supplements):
If you have a written list, the receptionist would be more than happy to make a copy.

_____

_____

_____

Please list any allergies you have (include medications, foods, animals, etc):

_____

_____

Pupil Dilation Information

Our office is committed to your eye health as well as ensuring you the best possible vision.
We recommend pupil dilation in addition to the routine eye examination.

What are the side effects?
Blurred near vision and light sensitivity for up to 6 hours. Driving is not usually impaired, but may require extra caution.

_____ Yes, I would like pupil dilation in order to ensure the health of my eyes.

_____ No, I understand the importance of pupil dilation, but elect not to be dilated at this time.

Signature: _____ Date: _____
(If you are under the age of 18, your parent's signature is required)

We are a HIPAA Compliant Office.

Thank You

RETINAL IMAGING

We at Experts On Sight are proud to offer highly advanced Scanning Laser Retinal Imaging, which allows us to take images, safely, quickly and easily. A Scanning Laser Retinal Exam produces an image that is as unique as your fingerprint and provides us with a high resolution look at the health of your retina.

Many eye problems can develop without you knowing. You may not even notice any change in your sight. But, diseases such as macular degeneration, glaucoma, other health problems such as diabetes and high blood pressure can be seen with a thorough exam of the retina.

Retinal Exam provides:

- A scan to show a healthy eye or detect disease.
- A more detailed view of the retina, giving your doctor an image that can't be obtained by any other means.
- The opportunity for you to view and discuss the Retinal Image of your eye with your doctor at the time of your exam.
- A permanent record for your file, which allows us to view your images each year to look for changes.

We strongly recommend that all of our patients receive this evaluation. It is especially important for those patients who spend significant time looking at digital screens such as COMPUTER MONITORS, HDTV's, LAPTOPS, TABLETS, CELL PHONES etc. have a history of high blood pressure, diabetes, retinal problems or have a family member which suffers from retinal problems.

This state of the art procedure requires an addition 3 to 5 minutes of your time and there is an additional fee of only **$39.00. We strongly recommend that children also be scanned.****

Please check YES or NO below and sign.

_____ YES, I would like an examination including the Scanning Laser Retinal Imaging.

_____ NO, I understand the importance of Digital Retinal Imaging and understand this test would be in my best interest, but, at his time, I prefer the General Eye Examination only which will not include the Digital Retinal Imaging.

Signature: _____ Date _____

**Please note that while this test is "optional" for some individuals, it represents preventative health care for others. It may be required to "rule-out "certain eye diseases. In the latter case, you may be able to submit your bill for the retinal image or we will bill it on your behalf. Subject to change at any time.

EXPERTS ON SIGHT

DEQ 5

Name: _____ DOB: _____ Date: _____

1. QUESTIONS ABOUT **DRY DISCOMFORT**:
   A. During a typical day in the past month, how often did your eyes feel discomfort?

0 ☐ Never
1 ☐ Rarely
2 ☐ Sometimes
3 ☐ Frequently
4 ☐ Constantly

   B. When your eyes felt discomfort, how intense was this feeling of discomfort at the end of the day, within two hours of going to bed?

Never have it . Not at all intense Very Intense

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

2. QUESTIONS ABOUT **EYE DRYNESS:**
   A. During a typical day in the past month, **how often** did your eyes feel dry?

0 ☐ Never
1 ☐ Rarely
2 ☐ Sometimes
3 ☐ Frequently
4 ☐ Constantly

   B. When your eyes felt dry, **how intense was this feeling of dryness** at the end of the day, within two hours of going to bed?

Never have it . Not at all intense Very Intense

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

3. QUESTION ABOUT **WATERY EYES**:

During a typical day in the past month, **how often** did your eyes look or feel excessively watery?

0 ☐ Never
1 ☐ Rarely
2 ☐ Sometimes
3 ☐ Frequently
4 ☐ Constantly

EXPERTS ON SIGHT

OFFICE USE ONLY

Score: 1a	+	1b	+	2a	+	2b	+	3	=	Total
_____	+	_____	+	_____	+	_____	+	_____	=	_____

0-5 Low Risk 6-10 Dry Eye Eval 11+ Sjogren's Eval

Experts on Sight, LLC
3303 S Lindsay Rd, Ste 101
Gilbert, AZ 85297
480-292-9835 phone 480-292-9836 fax

CONTACT LENS EVALUATION INFORMATION

Contact lenses are medical devices controlled by the FDA and there is an expected "standard of care" required for contact lens wearers. We are dedicated to providing quality care to ensure your optimal comfort, vision, and most importantly, eye health.

It is not possible to determine in advance whether or not you will be a successful contact lens wearer, due to many factors that can influence your success. These factors include, but are not limited to: your expectations; unusual prescription; corneal shape; eyelid anatomy; manual dexterity; allergies; tear quantity; use of certain medications; willingness to return for follow-up care; improper lens care; and inability to follow lens care instructions or wearing schedule. Please discuss any factors you think may be a potential problem with the doctor before the lens fitting process.

There is a contact lens evaluation fee (starting at $90) which covers the initial evaluation to determine the most appropriate lenses and any additional contact lens related visits for up to 60 days. Additional fees will be charged in cases where extra follow-up visits or additional diagnostic lenses are required. In the event of any irritations or infections during the course of the fitting, the doctors will manage your eye(s) as a medical condition. The remainder of the contact lens evaluation will resume after the medical issue is resolved. We will provide a full lens care kit and instructions on caring for and wearing the lenses, including teaching insertion and removal of lenses.

A routine comprehensive eye exam is required in order to complete any contact lens fitting and evaluation. If it has been more than 3 months since your last routine eye exam, you will be required to have a complete comprehensive eye exam as well as a contact lens evaluation in order to be prescribed contact lenses.

Boxes of contacts can only be returned for an exchange if they are **unopened, unmarked, do not expire within 2 years, and in original condition, within 3 months.** **Professional fees and lens care products are non-refundable**.

We appreciate your selection of our office to provide your contact lens services. We will do everything possible to affirm your continued trust in our care. If you have any additional concerns or questions, please do not hesitate to ask our doctors' or courteous team members.

_____ _____
Patient's Name Date

_____
Patient Initial/Parent Initial if minor

HIPAA ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Experts on Sight
3303 S Lindsay Rd Ste 101
Gilbert, AZ 85297
480-292-9835

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

Provide and coordinate my treatment among a number of healthcare providers who may be involved in that treatment directly and indirectly

Obtain Payment from third party payers for my health care services

Conduct normal healthcare operations such as quality assessment and improvement activities

I have been informed of my healthcare provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my health care provider has the right to change the Notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

IF EXPERTS ON SIGHT IS BILLING INSURANCE ON MY BEHALF, I AUTHORIZE THEM TO OBTAIN (FROM MY INSURANCE CARRIER) ANY INFORMATION NEEDED REGARDING BENEFITS AND MAXIMUMS AVAILABLE, SERVICES PROVIDED BY HIM OR ANY OTHER OPTICAL PROVIDER OF CARE THAT WILL HELP HIS OFFICE TO OBTAIN BENEFITS ON MY BEHALF. ALL BENEFITS ARE ASSIGNED TO EXPERTS ON SIGHT.

Patient Name: _____ Date: _____

Signature: _____

For office use only:
We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reasons:

- □ The patient refused to sign
- □ Communication barriers
- □ Emergency situation