Welcome to Capella Eyecare

Today's Date_____ E-mail Address_____

Patient's Name _____ Age _____Date of Birth _____ Sex ❑M ❑F

Address_____

Street City State Zip

Telephone (Home) (___)_____ (Work) (___)_____ (Mobile) (___)_____

SS # _____ Guardian's Name(if minor) _____ Student, Grade _____

School _____ Employer/Occupation_____

Name of Insured on Account _____ Relationship to Patient _____

Payment Preference ❑Cash ❑Credit Card Do you have insurance? ❑Yes ❑No

Medical Insurance Provider _____ I.D. Number _____

Eyecare Insurance Provider _____ I.D. Number _____

How did you hear about us? ❑Family/Friends ❑Insurance Plan ❑Internet
❑Previous Patient ❑Walkby ❑FB/Connections

Are you on Facebook/Twitter? _____

Who may we contact in case of an emergency? _____ Telephone (___)_____

Eye History/Ocular Review of Systems

Approx. date of last eye examination _____ By Doctor _____
Do you wear glasses? ❑Yes ❑No If yes, when were they prescribed? _____
Do you wear contact lenses? ❑Yes ❑No If yes, when were they prescribed? _____
Would you like to wear contact lenses? ❑Yes ❑No Have you ever worn contact lenses? ❑Y ❑N
Are you interested in refractive surgery (LASIK)? ❑ Yes ❑ No
Do you wear sunglasses? ❑Yes ❑No
Do you have problems with ❑ Distance tasks ❑ Near tasks ❑ Both ❑ Neither
Do you currently have or have you ever had any of the following problems?

❑ Loss of vision	❑ Excess tearing/watering	❑ Eye pain
❑ Blurred Vision	❑ Mucous Discharge	❑ Eye infections
❑ Distorted Vision	❑ Redness	❑ Eye injuries
❑ Loss of side vision	❑ Itching	❑ Eye Surgery
❑ Double Vision	❑ Burning	❑ Retinal detachment
❑ Macular degeneration	❑ Foreign body sensation	❑ Cataracts
❑ Floaters in vision	❑ Sandy/Gritty feeling	❑ Glaucoma
❑ Flashes of light in vision	❑ Eye strain/Tired eyes	❑ Dry Eyes
❑ Twitching eyelids	❑ Light sensitivity/Glare	❑ Crossed / Lazy eye
❑ Kerataconus	❑ Corneal disease	❑ Retinal disease

Medical History

Are you presently taking ANY medications (including OTC meds, hormones, supplements, or birth control)? ❑Yes ❑No
If yes, please list

_____

_____

Do you have any allergies to medications? ❑Yes ❑No If yes, please list _____

_____

List all major injuries, surgeries, and/or hospitalizations you have had _____

_____

Are you pregnant and/or nursing? ❑Yes ❑No
Approximate date of last general health exam _____ Family Physician _____

Social History

Are you: ❑Married ❑Single ❑Divorced ❑Widowed Do you drive? ❑Yes ❑No
Do you use a computer? ❑Yes ❑No If yes, how many hours per day?_____
What are some of your hobbies? _____

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:_____
Do you use illegal drugs? ❑Yes ❑No If yes, type/amount/how long:_____
Have you ever been exposed to or infected with any of the following?
❑Gonnorrhea ❑Hepatitis ❑HIV ❑Syphilis

Family History ❑Adopted

Please note any family history (parents, grandparents, siblings, children, aunts, uncles) for the following conditions:

Condition	Yes	No	?	Relationship to You
Blindness	❑	❑	❑	
Cataracts	❑	❑	❑	
Glaucoma	❑	❑	❑	
Crossed/Lazy eye	❑	❑	❑	
Macular degeneration	❑	❑	❑	
Retinal detachment	❑	❑	❑	
Retinal Disease	❑	❑	❑	
Diabetes	❑	❑	❑	
High blood pressure	❑	❑	❑	
Heart Disease	❑	❑	❑	
Thyroid disease	❑	❑	❑	
Rheumatoid arthritis	❑	❑	❑	
Cancer	❑	❑	❑	
Keratoconus	❑	❑	❑	

Review of Systems

Do you currently or have you ever had any problems in the following areas?

System	Yes	No	?
Constitutional (fever, weight loss, gain)	❑	❑	❑
Integumentary (skin)	❑	❑	❑
Neurological			
Headaches/Migraines	❑	❑	❑
Seizures	❑	❑	❑
Multiple sclerosis	❑	❑	❑
Ear, Nose, Mouth, Throat			
Allergies, Hay fever	❑	❑	❑
Sinus congestion	❑	❑	❑
Runny Nose	❑	❑	❑
Chronic cough	❑	❑	❑
Dry throat/mouth	❑	❑	❑
Cancer	❑	❑	❑
Respiratory			
Asthma	❑	❑	❑
Chronic Bronchitis	❑	❑	❑
Emphysema	❑	❑	❑
Pyschiatric	❑	❑	❑
Allergic/Immunologic	❑	❑	❑
Endocrine(Thryoid/Other glands)	❑	❑	❑

	Yes	No	?
Vascular/Cardiovascular			
Diabetes	❑	❑	❑
High blood pressure	❑	❑	❑
Heart attack	❑	❑	❑
Vascular disease	❑	❑	❑
Heart disease/pain	❑	❑	❑
High Cholesterol	❑	❑	❑
Gastrointestinal			
Constipation	❑	❑	❑
Diarrhea	❑	❑	❑
GERD/Ulcers	❑	❑	❑
Genitourinary	❑	❑	❑
Bones/Joints/Muscles			
Rheumatoid arthritis	❑	❑	❑
Muscle pain	❑	❑	❑
Joint pain	❑	❑	❑
Lymphatic/Hematologic			
Anemia	❑	❑	❑
Bleeding problem	❑	❑	❑

Authorization

I certify that the above questions have been accurately answered to the best of my knowledge. I authorize the doctor to release any information including the diagnosis and the records of any treatment given to me or my dependents to third party payers and/or health practitioners. If applicable, I authorized my insurance company to pay directly to the doctor insurance benefits on my behalf. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be ultimately responsible for payment of services rendered to me or my dependents.

Signature of Patient (or guardian if minor) Today's Date

Additions (for doctor use)

Doctor's Signature Today's Date

VISUAL FIELD TESTING $25

This screening checks for visual field defects, both in central and peripheral areas. This test measures the function and sensitivity of the retinal to light. Visual field screening can assist the doctor in early detection of glaucoma, retinal detachment, brain tumors, optic nerve swelling, visual related neurological diseases, and other possible
causes of headaches. This test is especially important for those who have the following conditions:

- Seeing floaters, "spots" or flashes of light
- Headaches
- High blood pressure
- Heart/ circulatory problems
- Head injuries
- Strokes
- History of diabetes
- Strong eyeglass prescription
- Blurry vision without apparent reason.

Please check one and sign below.

_____ YES I want the visual field _____ NO I DO NOT wish to have a visual field

RETINAL IMAGING PHOTOS $39

As part of your eye exam Dr. Anh Jibben recommends a special diagnostic procedure called **Wellness Retinal Imaging**. This procedure consists of capturing a high quality digital image of the back part (retina) of your eye. This is not an x-ray or ultrasound procedure; and nothing will touch your eye. We are simply taking a digital image of the back of your eye.

This permanent record is very valuable in assessing the current health of your eye and for safeguarding the health of specific structures of your eye, such as the retina, optic nerve, macula, and blood vessels. It will also serve as an initial point from which to compare, as we follow your health in subsequent years.

This test is ***NOT COVERED*** under your medical insurance. Retinal images are also NOT covered under vision plans. It is important to document the findings of most retinal diseases and conditions to monitor and preserve your vision. This test is important for detecting the following conditions:

- Recent trauma, fall or injury, car accident, or stroke
- Macular degeneration, Glaucoma
- Tumors
- Hemorrhages
- Diabetic eye disease
- Hypertensive retinopathy
- Retinal holes / Retinal detachments
- Strong glasses or contact lens prescription
- Rare life-threatening cancer: colon cancer, lymphoma, brain cancer, multiple myeloma, pancreatic cancer

Please check one and sign below.

_____ YES I want to have the retinal imaging _____ NO I DO NOT want to have retinal imaging

*****We strongly believe in the early detection and treatment of all ocular disease and conditions and strongly recommend all patients to have both procedures performed. ******

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

When provided the necessary information prior to an appointment, the staff of Capella Eyecare makes every attempt to verify patient's benefits. In addition, the staff will gladly file insurance claims on behalf of the patient. The insurance carrier will review the claim and accept or deny coverage as they deem appropriate. Should the insurance company deny coverage, it is the patient's responsibility to pay any and all of the balance to Capella Eyecare.

The staff at Capella Eyecare can give you a general idea of what may or may not be covered by your insurance plan before seeing the doctor. However, we cannot always know for certain what services will be provided by the doctor before the examination. Whether the visit will be filed with a vision carrier or a medical carrier is dependent on several factors including but not limited to patient's reason for visit, type of exam performed, and diagnoses. Any diagnosis other than a routine vision diagnosis will result in a medical claim submittal. At times, patients may be able to use both medical and vision benefits to maximize patient's benefits.

HIPAA PRIVACY ACKNOWLEDGEMENT

I have received the HIPAA notice of privacy practices and have been provided an opportunity to review it. By signing below, I acknowledge that I have read and understand the above form. I understand that the eye examination and/or the fitting of contact lenses are medical services and are therefore **NON-REFUNDABLE**.

By signing below, I acknowledge that I have read and understand the above statements.

Signature: _____ Date: _____

NOTICE FOR NEW AND ESTABLISHED CONTACT LENS WEARER

A **CONTACT LENS EVALUATION FEE** is necessary to determine the contact lens prescription or to renew your current contact lens prescription annually, despite any changes. This evaluation fee will include an assessment of the health of the corneas, precise measurements of your prescription and recommendations of materials and prescription tailored for you. It will also include a sample of diagnostic lenses based on your examination today. The prescription for contact lenses will NOT be given or finalized unless a contact lens evaluation is completed.

CONTACT LENS EVALUATION FEE: The fees listed below are **in addition** to the regular examination fee. The fee will cover the initial evaluation of my contacts and any subsequent follow-up appointments during the first **THIRTY DAYS.** After thirty days, any follow-up visits will be charged accordingly.

	I am aware the contact lens evaluation fees are non-refundable.
Soft spherical/ Colors	$60
Toric/Astigmatism/ Multi-focals / Monovision	$80
Gas Permeable/ Rigid lenses/ RGPs	$100
FIRST TIME WEARER: Soft spherical lens evaluation	$100

☐ I currently do not wear contacts and would like to try them.

☐ I currently wear contacts and would like to renew my prescription.

☐ I currently wear contacts and DO NOT wish to renew my prescription. I understand I **will not be able** to order any contacts until I have a contact lens evaluation.

I hereby acknowledge that insurance plans will only cover either my glasses or contacts. I am aware they do NOT cover both (unless otherwise noted). I also understand that contact lenses are considered a medical device and a contact lens evaluation is necessary before my prescription is finalized. The contact lens prescriptions are valid for ONE YEAR and be re-evaluated every year to ensure a proper fit, acceptable vision and good ocular health.

Print Patient Name:_____

Patient or Guardian Signature: _____Date:_____

Dr. Anh Jibben, O.D., M.P.H.
12625 N. Saguaro Blvd., Suite 106
Fountain Hills, AZ 85268
480.656.2111

REQUEST FOR RECORDS

Today's Date:_____

Patient Name:_____

Patient DOB:_____

To Whom it may concern:

I am authorizing the release of my records to be sent to the number listed below. Please fax my records to their office at your earliest convenience. Thank you for your attention to this request.

Capella Eyecare

12625 N. Saguaro Blvd., Suite 106
Fountain Hills, AZ 85268
FAX: 480.621.8879

_____ _____

Patient Signature **Date**