ONLINE PATIENT INFORMATION

Date:______________

Name:____
Last First

D.O.B________/________/________
month date year

Address:____

City/State:_________________________________Zip:_______________

Home Phone:____

Work Phone/Cell Phone:_______________________________________

Social Security Number: __XXX_/__XX___/__________

Emergency Contact Person;_____________________________________

Emergency Contact Person Number: _____________________________

Employer/Occupation:____

Hobbies:____

Number of hours using computer /iPad/ Smartphone:______________ hrs/day

How did you hear about us? ○ Family/Friends ○Insurance plan
○ Internet ○Facebook ○ Previous patient ○Walk-by ○ Other:__________

Health Insurance:____
* Please verify that we accept your health plan.

Email: ____

EYE HEALTH HISTORY

Reason for today's exam:______________________________________

List all eye symptoms:_____________________________________

*Medical insurance only covers if there is a medical reason for the exam such as loss of vision, headaches, eye redness, eye pain, itching, burning, glaucoma, dry eyes, cataracts, etc.

Please expand on your eye symptoms by circling:

Location	Which eye has the problem?	Right /Left /Both
Quality	Does problem cause vision loss or blur?	Loss/ Blur
Context	Did problem occur suddenly/ gradual?	Sudden/ Gradual
Severity	How severe is problem?	Mild/ Moderate/ Severe
Modify	Is it worse at specific distance?	Distance/ Near/Computer
Duration	How long does problem last?	Intermittent/ Constant
Timing	How long has problem been occurring?	Short term/ Long term
Other	Are there other symptoms?	Explain:____________________________

____

Previous Intervention Does anything help the problem? Nothing helps/ Yes explain:

____

Last eye exam: ____________By Whom: □ Dr. Jibben □ Other:________________

Have you ever had any of the following? □ **None**

- □ Amblyopia (Lazy Eye)
- □ Glaucoma
- □ Cataracts
- □ Diabetic Retinopathy
- □ Prosthetic Eye
- □ Vision Therapy / Patching
- □ LASIK (what year):______
- □ Keratoconus
- □ Macular Degeneration
- □ Dry Eyes
- □ Retinal Detachment
- □ Ptosis/ drooping eyelid
- □ Lid Surgery
- □ Cataract Surgery
- □ Other: ____

Do you currently have any of the following:

- □ Loss of vision
- □ Blurred vision
- □ Distorted vision/halos
- □ Loss of side vision
- □ Double vision
- □ Foreign body sensation
- □ Excess tearing/watering
- □ Chronic infection of eye or lid area
- □ Mucous discharge
- □ Redness
- □ Sandy/gritty feeling
- □ Itching
- □ Burning
- □ Glare light sensitivity
- □ Eye pain / soreness
- □ Styes/ Chalazion
- □ Tired eyes
- □ Flashes/ Floaters
- □ Dry eyes

READ BACK PAGES / SIGNATURE REQUIRED

CONTACT LENS □ I DO NOT WEAR CONTACTS

Would you like to try contacts? □ Yes □ No

Do you overwear your contacts? □ Yes □ No How many days?________

How many days do you sleep in your contacts/week:____________________________

Brand/Type of contacts__________________________________Hours/Day__________

Do you own a current pair of glasses? □ Yes □ No

REVIEW OF SYSTEMS

Medical History Reviewed □ Healthy □ No Change

Who is your family doctor?__________________________________

Check all medical conditions that you have or been diagnosed with recently:

- □ Allergies/ Hay fever
- □ Anemia/ Bleeding
- □ Arthritis/ Rheumatoid Arthritis/ Gout / Joint pain
- □ Asthma/ Shortness of breath/ TB / Emphysema
- □ Bell's Palsy
- □ Bladder or Kidney problems
- □ Cataracts
- □ Cancer Type:____
- □ Cholesterol Elevated
- □ Chronic Bronchitis
- □ Chronic Cough
- □ Diabetes: Last blood sugar:_______mg/dl HbA1C:_______%
- □ Dry Throat/ Mouth/ Chronic ear infections
- □ Gastro/ Intestinal/ Irritable Bowel Syndrome/ Crohn's Disease
- □ Headaches/ Migraines
- □ Head trauma
- □ High Blood Pressure: Last blood pressure reading:_______/_________
- □ Lupus
- □ Multiple Sclerosis
- □ Past Trauma:____
- □ Psychiatric disorders/ Nervous disorders/ Depression / Anxiety
- □ Recent weight loss/ gain / Fever
- □ Rosacea
- □ Seizures
- □ Sjogren's
- □ Sinus problems
- □ Skin Rash/ Skin Cancer
- □ Thyroid Disease/ other glands:______________________________
- □ Other:____

Are you pregnant? □ No □ Yes How many weeks:____________

Tobacco use: □ No □ Yes Explain: ___________________

Alcohol use: □ No □ Yes Explain: ___________________

HIV or AIDS positive □ Yes □ No T4 cell count:__________cells/mm3

Have you ever been exposed to/ infected with the following below:
□ Gonorrhea □ Syphilis □ Hepatitis

FAMILY HISTORY □ None □ Adopted

Check any conditions below for which any family members (parents, grandparents, siblings, children) have been diagnosed or treated:

- ___ Arthritis
- ___ Cancer
- ___ Diabetes
- ___ Heart Disease
- ___ High blood pressure
- ___ Kidney Disease
- ___ Lupus
- ___ Thyroid Disease
- ___ Blindness
- ___ Cataract
- ___ Color blindness
- ___ Glaucoma
- ___ Lazy eye /Crossed eyes
- ___ Macular Degeneration
- ___ Retinitis Pigmentosa
- ___ Retinal Detachment

Other:____

MEDICATIONS □ None

List any medications you are currently taking, including eye drops, over-the-counter, & oral contraceptives.

____
____
____

DRUG ALLERGIES □ None

Do you have any DRUG allergies to medicine? List below:

____
____

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

VISUAL FIELD TESTING $25

(IN ADDITION TO YOUR COMPREHENSIVE EYE EXAM)

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 the 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:

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

Please check one:___ YES _____ NO _____ I WOULD LIKE TO DISCUSS WITH THE DOCTOR

RETINAL IMAGING PHOTOS $39

(IN ADDITION TO YOUR COMPREHENSIVE EYE EXAM)

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 NOTcovered 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:

- **Flashes, Floaters/ "spots", Headaches**
- **Recent trauma, fall or injury, car accident, or stroke, blurry vision, loss of vision**
- **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:___ YES _____ NO _____ I WOULD LIKE TO DISCUSS WITH THE DOCTOR

HIPAA PRIVACY ACKNOWLEDGEMENT

I have received the HIPAA notice of privacy practices and have been provided an opportunity to review it. I give permission to release health information to (1) my spouse (2) any family member (3)
others:____

By signing below, I acknowledge that I have read and understand the above form. I understand that the eye examination and/or the fitting and evaluation 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: ______________

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 the 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.

REFRACTION: In addition, Medicare does not cover the refractive test required to determine the prescription of your glasses. Patients are responsible for this fee if they wish to update the prescription.

EYEWEAR PURCHASE: All prescription glasses are custom eyewear, therefore, cannot be returned/ exchanged or refunded. All sales of prescription glasses are final. By signing below, I understand and acknowledge the above statement.

MEDICAL OFFICE VISIT	ROUTINE EYE EXAM
• Billed to medical insurance carrier o (BCBS, Medicare, etc.) • Includes red eyes, eye pain, injury to the eye, eye infections, and sudden vision loss. • Cataracts, glaucoma, macular degeneration	• Wellness exam (check-up for your eyes) • For patients with no eye disease • If a disease is found, the doctor may want to discuss whether you should switch to a medical exam.

Signature: ____ Date: __________

Dr. Anh Jibben, OD, MPH
12625 N. Saguaro Blvd., Suite 106
Fountain Hills, AZ 85268

REQUEST FOR PATIENT 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
480-656-2111
Fax: 480-621-8879

Patient Signature:______________________________ Date:________________________

NEW AND ESTABLISHED CONTACT LENS WEARER

CONTACT LENS EVALUATION FEE:

- A lens evaluation is necessary to determine the health of the corneas and recheck the contact lens prescription despite any or no changes in your vision.
- The evaluation fees listed below are **in addition** to the regular examination fee.
- The evaluation fees cover the diagnostic lenses during the one-month evaluation period.
    - Training session needed to help insert and remove the contacts for all first-time wearers.
    - Include any subsequent follow-up appointments during the first **THIRTY DAYS.** After thirty days, any follow-up visits will be charged accordingly.
- This evaluation fee does not cover treatment of red eyes/ infections or injuries.
- The prescription for contact lenses will NOT be finalized until the contact lens evaluation is completed.

	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 / Specialty Fits	$150
FIRST-TIME WEARER: Soft spherical lens evaluation	$150

☐ I DO NOT wear contacts and would like to try them.

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

☐ I 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:__________