Welcome To Our Office — *Alvarez Reigstad Optometry PC*

Patient Information – Please Print and fill out completely in ink.

Insurance (vision/medical)_____ SS#_____

Last Name_____ First Name_____ MI_____

Birth date _____ Age ____ If under 18, Parents Name _____

Address_____ City _____ State _____ Zip_____

Home Ph # _____ Other Ph # _____ Occupation _____

Email address _____

Emergency Contact _____ Phone # _____

Medical History – Please indicate if ***you*** have had or currently have any condition(s) listed below:

___ Dry Eye	___ Flashes of Light	___ Glaucoma	___ Asthma
___ Red Eye	___ Floaters	___ Diabetes	___ Retinal Disease
___ Itchy Eye	___ Headaches	___ Heart Condition	___ HIV/AIDS
___ Eye Injury	___ Lazy/ Turned Eye	___ Thyroid Condition	___ High Blood Pressure
___ Double Vision	___ Eye Surgery	___ Arthritis	___ High Cholesterol

Is there a family history of: ___ Diabetes ___ High Blood pressure ___ Glaucoma ___ Retinal Disease

Reason for today's visit: ___ Routine exam ___ Contact Lenses ___ Vision Problem ___ Other

Any known allergies to medications: _____

List of medications (include non-prescription):_____

Do you play sports? Y/N Which ones? _____

Have you ever worn contact lenses? _____ When? _____ Brand of Contacts_____

Are you interested in LASIK eye surgery? _____

I hereby assign and transfer to Dr. Alvarez-Reigstad Optometry PC all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. (initial here_____).

I understand that I am financially responsible for all charges whether or not they are covered by insurance. (initial here_____).

I authorize the vision care staff to perform the necessary health care services that I may need. I hereby agree that I am solely responsible for paying for all products ordered and services rendered (initial here____).

As required by federal law, a copy of the office's Notice of Privacy Practices has been provided to me. I understand that it is my right to have a take-home copy upon request, or for recycling purposes I can utilize the laminated in-office copy provided (initial here _____).

_____	_____	_____
Today's Date	Patient or Guardian Signature	Print Name of Signer

Alvarez Reigstad Optometry, PC

DIGITAL RETINAL IMAGING

Our office offers digital retinal imaging, which uses a computer-integrated digital imaging system to record a detailed view of the retina. Since nothing touches the eye, photo-documentation is painless. This digital image provides an excellent reference point for future comparisons. Retinal photography assists in the OVERALL EVALUATION OF YOUR EYE HEALTH, as well as detection and management of problems such as diabetic changes, hypertensive retinopathy, macular degeneration, optic nerve disease, and retinal holes or thinning. It is especially important for people with a history of high blood pressure, diabetes, retinal diseases, flashing lights, floaters, headaches, or a strong glasses prescription. For most healthy patients, we can obtain a digital retinal image rather than dilation. If we are unable to obtain a digital image, we will dilate. This test is recommended annually, and we highly recommend this testing for all patients.

The fee for this test is **$27.00** plus tax

I DO want to have this test done. **Initial**_____

I DO NOT want to have this test done. **Initial**_____

PERIPHERAL RETINAL EXAM

Drops allow the doctor to fully evaluate the health of the back of the eye. It is especially recommended for diabetic patients, patients with decreased vision, patients over 60 years of age, or at an initial eye exam. Side effects of the procedure are temporary loss of ability to focus at near and light sensitivity. These usually subside within 2-6 hours after installation of the drops. Although some people choose to drive while dilated, it is not recommended. Disposable sunglasses will be provided for your comfort. This exam (or retinal imaging) is recommended annually.

The fee for this test is **$42.00** plus tax

I DO want to have this test done. **Initial**_____

I DO NOT want to have this test done. **Initial**_____

I understand that without a peripheral retinal exam my optometrist cannot completely evaluate the internal health of my eyes and thus cannot be held liable for ocular conditions that may exist but are not visible without dilation.

Initial_____

VISUAL FIELD TESTING

The visual field test is used to test and monitor peripheral vision. It gives the doctor very important information about the neurological function of the retina, optic nerve, and brain. Visual field analysis is an important tool in the early detection of glaucoma, brain tumors, diabetic retinopathy, hypertensive retinopathy, retinal holes or detachments, macular degeneration, and stroke. Visual field analysis is especially important for people who are near sighted, have headaches, see spots in their vision, have a history of diabetes and/or high blood pressure, have a family history of glaucoma, blindness, cataracts, or macular degeneration, or are over the age of 40.

The fee for this test is **$22.00** plus tax.

I DO want to have this test done. **Initial**_____

I DO NOT want to have this test done. **Initial**_____

Any vision test forms to be completed/signed by our providers for the MVD, employer, etc. will require a Visual Field Screening, Depth Perception Screening and Color Vision Test.

The fees for these additional exams will be:

Visual Field **$32.00**

Depth Perception **$10.00**

Color Vision **$10.00**

Please, initial the statement that applies to you.

Yes, I do need a vision test form completed and understand the charges associated. **Initial**_____

No, I do not need a vision test form completed. **Initial**_____

FOLLOW UP PERIOD

All glasses and contact lens issues will be addressed free of charge within the first 60 days. If you wish to have a follow up and have exceeded the 60 day follow up period, you will be charged a fee of $40.00. After 6 months you will be charged a complete eye exam. Price of RGP/specialty lens follow ups may vary. We urge you to contact our office as soon as you start noticing any issues with your new prescription.

I understand that I will be charged a fee for follow ups if I exceed the 60 day follow up period.

Initial_____

ALVAREZ REIGSTAD OPTOMETRY, PC

AUTHORIZATION SHARING WITH FAMILY AND FRIENDS

CONSENT TO DISCLOSE MEDICAL AND PAYMENT INFORMATION

Patient Name: _____ Date of Birth: _____

Please CHECK one of the following:

_____ I give permission to Alvarez Reigstad Optometry, PC to disclose my/my child's Protected Health Information and payment information to me and the following friends and family:

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

_____ I request that my Protected Health Information be disclosed only to me and no other friends or family.

Patient or Guardian Signature: _____ Date: _____

Print name of signer: _____ Relation: _____