

Nelson C Klaus Jr OD | Jessica Stephenson OD

910-799-0220 3910 Shipyard Blvd., Wilmington, NC 28403 atlanticvisioncenter.com

Welcome to Atlantic Vision Center

Your appointment is scheduled with

___ Dr. Klaus

on _____ / ____ / _____ at _____ AM/PM.

___ Dr. Stephenson

Please bring your insurance cards (vision and medical) and photo ID. Plan to arrive 15 minutes early so that we may verify your benefits before your appointment begins. Be sure you thoroughly complete all forms provided (front and back) and bring a list of your medications.

Bring your glasses with you to your appointment. If you wear contact lenses, please wear them in (as long as they can be worn comfortably) and bring a copy of your most recent contact lens prescription if you have it. This can be a paper copy from your previous doctor or a packaging label. Plan to stay out of your contacts for at least 2 hours after your exam as you will be dilated.

Our goal is to give every patient a complete and thorough exam. A comprehensive eye exam with dilation requires approximately 2 hours. Please plan accordingly. After dilation, you may experience some near vision blurriness. If you are uncomfortable with driving after having your eyes dilated, remember to make transportation arrangements for your appointment.

We look forward to welcoming you as a patient! Please do not hesitate to contact us with any questions you may have.

WELCOME TO OUR OFFICE
(Dependent Form)

Purpose of visit: ___ Visual Examination
 ___ Contact Lens Fitting
 ___ Other _____

CHILD's full name _____ ___ Male
(Please print) (First) (Middle) (Last) ___ Female

Ethnicity: White African American Native American Asian Hispanic Other: _____

Home address _____ Date of birth _____

City _____ State _____ Zip _____ **HOME** Phone _____ ☐

School: _____

Who recommended you to our office? _____

Name of physician(s) _____

Father's Name _____ Occupation _____

Father employed by _____ Phone _____ ☐

Mother's Name _____ Occupation _____

Mother employed by _____ Phone _____ ☐

[Please note] that cell phone numbers and e-mail will only be used as a last resort for appointment changes /confirmation.] **CELL** Phone _____ ☐
e-mail: _____

[PLEASE CHECK BOX ("☐ ") OF THE PREFERRED PHONE NUMBER TO BE CALLED]

Payment is expected when services are rendered unless other arrangements are made in advance. (If you are ordering glasses or contact lenses, a one-half deposit is required to place the order, and the balance is due when they are dispensed.) Thank you.

Person responsible for account *** _____

Method of payment: ___ Cash ___ Check ___ Visa ___ MasterCard ___ Debit Card

***** INSURANCE INFORMATION MUST BE PRESENTED BEFORE YOUR EXAM OR WE MAY NOT BE ABLE TO UTILIZE YOUR INSURANCE FOR YOUR SERVICES.**

I hereby authorize Dr. Klaus and Dr. Stephenson to release any information and medical history necessary to process my claim. I agree that a photographic copy of this authorization shall be as valid as the original.

Signed _____ Date _____
<Please use the space below to enter the current date and initial anytime this information is reviewed and updated. Thank you.>

(If you have authorization for MEDICAID, SERVICES FOR THE BLIND, or other agencies to cover your charges, please sign the above authorization and present your card or paperwork to the receptionist **before your exam.**)

The Newest Technology Is Available In Our Office

Our office is now equipped with a *Digital Retinal Imaging System* to provide you with an even more thorough health analysis of your eye than previously possible. The *Digital Retinal Imaging System* takes images of the retina (the inside layer of your eye) and assists us in the early detection of disorders such as glaucoma, macular degeneration, retinal detachments, diabetic conditions, and many other health and vision threatening conditions. In some cases, the images can provide detail that is not possible to get otherwise, even with the best examining scopes.

These baseline screening images will be stored in our computers and compared with images from future exams to allow us to detect even the smallest amount of change from one exam to the other. This allows for the earliest preventative measures to be taken. If a person wishes, they can easily obtain their own copies of these baseline digital images*.

It is strongly recommended that **all patients** (especially new patients) have this procedure performed and it is especially important for anybody who has any of the following:

- **Headaches, floaters, spots, or flashes of light**
- **A family history of diabetes, glaucoma, or macular degeneration**
- **If you smoke (increased risk for retinal problems and glaucoma)**
- **Elevated cholesterol or high blood pressure**
- **Attained the age of 40 or if this is your first time being examined in this office**
- **Very sensitive to lights (especially bright examination lights)**
- **A child (who may not be able to hold their eye open for the entire retinal exam)**

A fee of \$34 will be charged for the baseline screening retinal images **in addition to** your normal exam fee. If pathology is present, then additional detailed images will be taken and the usual \$72 charge will apply. Also, if pathology is found, a medical diagnosis will be determined and the \$72 charge will **possibly** qualify for a claim to be filed with your health insurance company. (We will file the charge with your insurance company for you, and you will be responsible for any co-pay or deductible). **If there is no disease diagnosis**, then the images are considered just baseline screening images, and no insurance claims can be filed. Please check the appropriate line and sign below. **(This procedure will not add any additional time to your visit today provided we know to take the images at the time your dilation drops are put in.)**

_____ **(YES) I DO** want the baseline-screening retinal images

_____ **(NO) I DO NOT** want the baseline-screening retinal images

Signature

Date

* To obtain copies, please provide us with a **new blank CD** and we will have them ready the next day.

(dba. Atlantic Vision Center)

NOTICE OF PRIVACY PRACTICES AND DISCLOSURE OF PHI

A federal regulations known as the "HIPAA Privacy Rule" requires that we provide you a detailed notice in writing of privacy practices. This notice is available to all patients who ask to read it. In this notice, we describe the ways that we may use and disclose health information about our patients. The HIPAA Privacy Rule requires that we protect the privacy of health information that identifies a patient or where there is a reasonable basis the information can be used to identify a patient. This information is called "protected health information" or "PHI". Below you can request how Atlantic Vision Center communicates information to you. You may also request that only certain individuals be given information about your health, treatment or other personal information. ***Please fill out the questionnaire below.***

PLEASE CONTACT ME IN THE FOLLOWING MANNER: Please circle your preferences.

HOME PHONE: _____

CELL PHONE: _____

Leave detailed message on VOICE MAIL Y N

Leave detailed message on VOICE MAIL Y N

Leave detailed message with a PERSON Y N

Leave detailed message with a PERSON Y N

Name of Individual: _____

Name of Individual: _____

• A call back message stating the office called, a contact name and telephone number will be left at the numbers that you have answered NO.

WORK PHONE: _____

Leave detailed message on PERSONAL VOICE MAIL Y N

- Messages will not be left with a person at your work telephone unless you specifically indicate the name of the individual in the following space: _____
- ALL correspondence mailed will be in a sealed envelope addressed only to you, the two (2) exceptions are post cards to notify you that you have an appointment or that products are ready for you.

I authorize Atlantic Vision Center Optometrists and/or staff to discuss my PHI with the following individuals:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

I acknowledge that I have been given the opportunity to read Atlantic Vision Center Notice of Privacy Practices and understand that the above will remain in effect until revised by me.

Patient/Legal Representative Signature: _____ Date _____

Staff Member Witness: _____ Date _____

Medical History Questionnaire

Atlantic Vision Center

3910 Shipyard Blvd, Wilmington, NC 28403

(910) 799-0220

Name: _____ Today's Date: _____

Date of Birth: _____ Last Eye Exam: _____ Occupation: _____

Please fill out this form in it's entirety. If a section does not apply to you, please write "none".

Medications: (ONLY list Rx and non-Rx medications here; list all VITAMINS below. **If you have a list, we can copy it. **)

_____	_____	_____
_____	_____	_____
_____	_____	_____

Vitamins: _____

Do you have any allergies to medications? Yes ☐ No ☐

If Yes, please list the medications and in parenthesis list what type of reaction is experienced.

EYE Surgeries (with dates): _____

EYE Diseases (i.e. glaucoma, AMD, etc) _____ **If none** check here: ☐

OTHER Surgeries: _____

Do you currently have any problems with the following areas? If Yes, please explain.

Eyes

	Yes	No	Explanation:
Ocular Disease (glaucoma, cataracts, retinal disease, etc)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loss of vision, blurred vision, or fluctuating vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Floaters and/or Flashes (please explain)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Redness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mucous discharge or drainage	<input type="checkbox"/>	<input type="checkbox"/>	_____
Foreign body sensation, sandy or gritty feeling	<input type="checkbox"/>	<input type="checkbox"/>	_____
Itching, burning, watering (excessive tearing)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye pain/soreness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glare/light sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed eyes or "lazy eye" (amblyopia)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Drooping eyelid	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyelid issues (stye, chalazion, blepharitis, etc)	<input type="checkbox"/>	<input type="checkbox"/>	_____

Family History (Please list relationship to patient and indicate maternal or paternal side.) If none, please check.

	None		None
Blindness _____	<input type="checkbox"/>	Diabetes _____	<input type="checkbox"/>
Cataracts _____	<input type="checkbox"/>	Hypertension _____	<input type="checkbox"/>
Glaucoma _____	<input type="checkbox"/>	Heart Disease _____	<input type="checkbox"/>
Macular Degeneration _____	<input type="checkbox"/>	Stroke _____	<input type="checkbox"/>
Retinal Detachment _____	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>

Social History

	Yes	No
Do you use alcoholic beverages (more than 2/day)?	<input type="checkbox"/>	<input type="checkbox"/>
If Yes, how much? _____		
Do you use tobacco in any form? (Past or present)	<input type="checkbox"/>	<input type="checkbox"/>
If Yes, how much? Or what year did you quit? _____		
Do you use narcotics? (prescription or recreational)	<input type="checkbox"/>	<input type="checkbox"/>
If Yes, which narcotic and why? _____		

Women Only: Are you currently pregnant or nursing? Yes ☐ No ☐

If Yes, how far along are you? _____
Or how long have you been nursing? _____

Continued on back



Cardiovascular

	Yes	No
Hypertension or Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Myocardial Infarction (Heart Attack)	<input type="checkbox"/>	<input type="checkbox"/>
Cerebrovascular Accident (Stroke)	<input type="checkbox"/>	<input type="checkbox"/>
Congestive Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>
Elevated Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>

Constitutional

Disorientation	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness or fainting	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain/loss	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>

Endocrine

Diabetes Mellitus or Insipidus	<input type="checkbox"/>	<input type="checkbox"/>
Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>
Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Renal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>

Gastrointestinal

Acid Reflux	<input type="checkbox"/>	<input type="checkbox"/>
Gastroesophageal Reflux (GERD)	<input type="checkbox"/>	<input type="checkbox"/>
Hepatic disease or Cirrhosis	<input type="checkbox"/>	<input type="checkbox"/>
Colitis or Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Inflammatory Bowel Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>

Genitourinary

Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>
Prostate Disorder/Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>
Uterine Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>

Head

Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough or Dry Mouth	<input type="checkbox"/>	<input type="checkbox"/>
Ear Infection or Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>
Headaches or Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>

Hematologic/Lymphatic

Breast Carcinoma	<input type="checkbox"/>	<input type="checkbox"/>
Anemia or Leukemia	<input type="checkbox"/>	<input type="checkbox"/>
Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>
Temporal Arteritis	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>

Immunologic

	Yes	No
Herpes Simplex or Zoster	<input type="checkbox"/>	<input type="checkbox"/>
HIV Positive or AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Histoplasmosis or Toxoplasmosis	<input type="checkbox"/>	<input type="checkbox"/>
Sjogren's Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>

Integumentary

Acne or Rosacea	<input type="checkbox"/>	<input type="checkbox"/>
Albinism	<input type="checkbox"/>	<input type="checkbox"/>
Dermatitis or Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>
Lupus	<input type="checkbox"/>	<input type="checkbox"/>
Scleroderma	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>

Musculoskeletal

Akylosing Spondylitis	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Down's Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Marfan's Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>

Neurological

Bell's Palsy	<input type="checkbox"/>	<input type="checkbox"/>
Horner's Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Myasthenia Gravis	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>

Psychiatric

Attention Deficit Disorder (ADD)	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimer's Disease	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety Disorder or Depression	<input type="checkbox"/>	<input type="checkbox"/>
Autism	<input type="checkbox"/>	<input type="checkbox"/>
Bi-Polar Disorder or Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>

Respiratory

Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
COPD	<input type="checkbox"/>	<input type="checkbox"/>
Sarcoidosis	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>

Physician's Name: _____

Are you being watched for **diabetes**? ☐ Yes ☐ No

Height: _____ inches Weight: _____ lbs

Approximate month/year of Last Physical: _____

Informed consent for pupil dilation. To have a thorough eye health examination, it is necessary to dilate the pupils. Be aware that for approximately 2 to 6 hours following dilation you may notice the following: blurred vision, extreme sensitivity to light, decreased depth perception, and even feeling "off balance". If you are concerned about your ability to function or drive after dilation, and do not have anyone with you to assist you, you can request to reschedule for dilation. However, your eye examination is not complete until the internal eye health has been examined with your pupils dilated.

Consent: I have read and understand the risk referred to above and hereby consent to having my pupils dilated today.

Signature of Patient/Guardian

Date

Tech Signature

Doctor's Signature