Welcome to Atlantic Vision Center

____ Male
Full name _____ ____ Female
(Please print) (First) (Middle) (Last) (Sr. Jr. III etc.)

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

Occupation_____ Employed by_____

Home address_____ Date of birth _____

City_____State_____Zip_____ **e-Mail:** _____

HOME Phone_____ ☐ **CELL** Phone_____ ☐

CHECK PREFERRED WAY TO BE CONTACTED

Preferred pharmacy: _____

Please circle: Single Married Widowed Separated Divorced Other: _____

Spouse's Name _____ Employer_____

How did you hear about us? _____

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

Person responsible for account _____

I hereby authorize Dr. Brigman, 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. **Please read below***

Signed _____ Date _____

***Insurance information must be presented before your exam or we may not be able to utilize your insurance for your services. Please sign the above authorization and present your card or paperwork to the receptionist *before your appointment begins*.**

Please use the space below to enter the current date and initial anytime this information is reviewed and updated.

Sara Brigman OD | Nelson C Klaus Jr OD | Jessica L Stephenson OD

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

(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)	☐	☐	_____
Loss of vision, blurred vision, or fluctuating vision	☐	☐	_____
Double vision	☐	☐	_____
Floaters and/or Flashes (please explain)	☐	☐	_____
Redness	☐	☐	_____
Mucous discharge or drainage	☐	☐	_____
Foreign body sensation, sandy or gritty feeling	☐	☐	_____
Itching, burning, watering (excessive tearing)	☐	☐	_____
Dryness	☐	☐	_____
Eye pain/soreness	☐	☐	_____
Glare/light sensitivity	☐	☐	_____
Crossed eyes or "lazy eye" (amblyopia)	☐	☐	_____
Drooping eyelid	☐	☐	_____
Eyelid issues (stye, chalazion, blepharitis, etc)	☐	☐	_____

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

	None		**None**
Blindness _____	☐	Diabetes _____	☐
Cataracts _____	☐	Hypertension _____	☐
Glaucoma _____	☐	Heart Disease _____	☐
Macular Degeneration _____	☐	Stroke _____	☐
Retinal Detachment _____	☐	Other: _____	☐

Social History	**Yes**	**No**
Do you use alcoholic beverages (more than 2/day)?	☐	☐
If Yes, how much? _____		
Do you use tobacco in any form? (Past or present)	☐	☐
If Yes, how much? Or what year did you quit? _____		
Do you use narcotics? (prescription or recreational)	☐	☐
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 (high blood pressure)	☐	☐
Heart Disease	☐	☐
Myocardial Infarction (Heart Attack)	☐	☐
Cerebrovascular Accident (Stroke)	☐	☐
Congestive Heart Failure	☐	☐
Elevated Cholesterol	☐	☐
Constitutional		
Disorientation	☐	☐
Dizziness or fainting	☐	☐
Weight gain	☐	☐
Weight loss	☐	☐
Fever	☐	☐
Nausea	☐	☐
Endocrine		
Diabetes Mellitus or Insipidus	☐	☐
Diabetic Suspect	☐	☐
Hypoglycemia	☐	☐
Crohn's Disease	☐	☐
Thyroid Disorder	☐	☐
Renal Disease	☐	☐
Gastrointestinal		
Acid Reflux	☐	☐
Gastroesophageal Reflux (GERD)	☐	☐
Hepatic disease or Cirrhosis	☐	☐
Colitis or Ulcer	☐	☐
Inflammatory Bowel Syndrome	☐	☐
Inflammatory Bowel Disease	☐	☐
Genitourinary		
Kidney Stones	☐	☐
Prostate Disorder	☐	☐
Prostate Cancer	☐	☐
Sexually Transmitted Disease	☐	☐
Uterine Cancer	☐	☐
Head		
Chronic Cough	☐	☐
Dry Mouth	☐	☐
Hearing Loss	☐	☐
Headaches	☐	☐
Migraines	☐	☐
Sinusitis	☐	☐
Hematologic/Lymphatic		
Breast Carcinoma	☐	☐
Anemia	☐	☐
Sickle Cell Disease	☐	☐
Temporal Arteritis	☐	☐
Leukemia	☐	☐

Immunologic	Yes	No
Herpes Simplex or cold sores	☐	☐
Herpes Zoster (shingles)	☐	☐
HIV Positive or AIDS	☐	☐
Sjogren's Syndrome	☐	☐
Integumentary		
Acne	☐	☐
Rosacea	☐	☐
Albinism	☐	☐
Psoriasis	☐	☐
Lupus	☐	☐
Scleroderma	☐	☐
Musculoskeletal		
Ankylosing Spondylitis	☐	☐
Arthritis	☐	☐
Rheumatoid Arthritis	☐	☐
Down's Syndrome	☐	☐
Marfan's Syndrome	☐	☐
Osteoporosis	☐	☐
Neurological		
Bell's Palsy	☐	☐
Horner's Syndrome	☐	☐
Multiple Sclerosis	☐	☐
Myasthenia Gravis	☐	☐
Seizures	☐	☐
Parkinson's Disease	☐	☐
Psychiatric		
Attention Deficit Disorder (ADD)	☐	☐
Alzheimer's Disease	☐	☐
Anxiety Disorder	☐	☐
Depression	☐	☐
Autism	☐	☐
Bi-Polar Disorder	☐	☐
Schizophrenia	☐	☐
Respiratory		
Asthma	☐	☐
Bronchitis	☐	☐
COPD	☐	☐
Sarcoidosis	☐	☐
Sleep Apnea	☐	☐
Do you use a CPAP?	☐	☐

Other:_____

_____

_____

Primary care provider: _____

Height: ____ft____ in **Weight:** _____ lbs

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

SARA BRIGMAN, OD
NELSON C. KLAUS, JR., OD
JESSICA L. STEPHENSON, OD

3910 SHIPYARD BOULEVARD
WILMINGTON, NC 28403
Telephone (910) 799-0220

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 $39 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 $79 charge will apply. Also, if pathology is found, a medical diagnosis will be determined and the $79 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.