# WELCOME TO THE OFFICE OF DR. DAVID J ANDERSON & ASSOCIATES

**Arcadia Eye Care**
**Dr. David J. Anderson**
**4350 E Camelback Rd. Ste B 120**
**Phoenix, AZ 85201**
**602-279-5855**

Patient Name: (last) _____, (first) _____ (m.i)_____

Patient Address: _____ City: _____State: _____

Zip: _____DOB: _____ (mm/dd/yy) Age:_____SSN: _____ Male / Female

Cell Phone: _____Home Phone: _____ Work Phone: _____

Email: _____Preferred method of contact: _____

Occupation: _____Reason for visit:_____Referred by:_____

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Do you plan on using any insurance? **Y** or **N**

Medical insurance: **Aetna** **BCBS** **Medicare** **United Healthcare** **Other**_____

Vision insurance: **Aetna Vision** **BCBS** **Eye Med** **VSP** **VCP** **Other**_____

Are you the primary account holder on your insurance? **Y** or **N**

Primary member's name: (last) _____, (first) _____

DOB: _____(mm/dd/yy) SSN: _____

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**Vision Examinations:** For "routine eye examination", glasses prescriptions and or contact lens fitting are billed through your *vision insurance plan*. Contact lens fitting/exams require additional follow up and care. Vision insurance can only be used for prescribing vision correction (refractions) Medical insurance can't be used for "routine refractions" and the purchase of contacts/glasses.
**Medical Examinations:** For treatment of eye infection, glaucoma, macular degeneration, diabetic retinopathy, and or other eye problems. Medical eye examinations require more time and documentation and additional professional judgement to identiy the reason and the appropriate treatment. Vision insurance plans such as Eye Med and VSP can not be used for medical examination.

## ALL PATIENTS ARE RESPONSIBLE FOR PAYMENT AT TIME OF SERVICE

Method of payment: CASH VISA/MASTERCARD DISCOVER AMEX CHECK

PATIENT ASSUMES FULL RESPONSIBILITY FOR PAYMENT OF SERVICES, COURT COST, ATTORNEY FEES, AND ANY OTHER COST INCURRED DURING COLLECTION OF DELINQUENT ACCOUNTS, AN ADDITIONAL $35 CHARGE WILL BE ADDED TO ANY RETURN CHECK. *PROFESSIONAL SERVICES FEES ARE NOT REFUNDABLE. EYE GLASSES ARE CUSTOM ORDERED TO FIT EACH INDIVIDUAL AND CAN'T BE RETURND OR REFUNDED.* NO REFUNDS/EXCHANGES ON OPEN BOXES OF CONTACTS. PRESCRIPTION RECHECKS AVAILABLE AT NO CHARGE FOR UP TO 30 DAYS FROM THE ORIGINAL EXAM DATE, FEES APPLY AFTER 30 DAYS. MEDICARE DOES NOT COVER ROUTINE EYE EXAM!

ACKOWLEDGEMENT OF RECEIPT OF HIPPA PRIVACY & INFORMATION RELEASE CONSENT

I AUTHORIZE ANY HOLDER OF MEDICAL OPTICAL INFORMATION TO RELEASE INFORMATION ABOUT ME TO DR. DAVID J ANDERSON & ASSOCIATES AND I AUTHORIZE DR. DAVID J ANDERSON & ASSOCIATES TO RELEASE MEDICAL OPTICAL INFORMATION ABOUT ME TO OTHER HEALTHCARE PROFESSIONALS, ATTORNEYS OR INSURANCE COMPANIES.

I HEREBY ACKOWLEDGE THAT I READ AND UNDERSTAND THE ABOVE INFORMATION. I ALSO HAVE BEEN PRESENTED AND OFFERED A COPY OF THE NOTICE OF PRIVACY POLICY FOR THE OFFICE OF DR. DAVID J ANDERSON & ASSOCIATES.

**SIGNED:**_____ **DATE:**_____/_____/_____

Dr. David J. Anderson & Associates

**Medical Case History**

Patient **Name:**_____(last), _____(first) **Age**_____

**Indicate what disease you have or are being treated for** **Check "ALL" Appropriate Boxes**

Review of Systems

**Constitutional** ❑None
❑Weight Loss
❑Fever
❑Fatigue

**Ears Nose Throat** ❑None
❑Chest cold
❑Flu
❑Sinus

**Cardiovascular** ❑None
❑Heart disease
❑Cholesterol
❑Stroke
❑Hypertension

**Respiratory** ❑None
❑Asthma
❑Bronchitis
❑Emphysema

**Gastrointestinal** ❑None
❑Ulcer
❑Digestive
❑Colitis

**Genitourinary** ❑None
❑Urinary tract infection
❑Kidney problem
❑Std ❑Herpes

**Musculoskeletal** ❑None
❑Arthritis
❑Muscular dystrophy
❑Fibromyalgia

**Integumentary** ❑None
❑Acne Rosacea
❑Eczema
❑Psoriasis
❑Shingles in past

**Neurological** ❑None
❑MS
❑Epilepsy
❑Seizures ❑Myasthenia Gravis

**Psychiatric** ❑None
❑Depression
❑Panic Disorder

**Endocrine** ❑None
Diabetes ❑Type 1 ❑Type 2
❑Thyroid dysfunction

**Blood Lymph** ❑None
❑Leukemia
❑Anemia

**Allergic/Immunologic** ❑None
❑Seasonal allergies
❑Lupus ❑Cancer

1. **Are you ALLERGIC** to any **Medications?** ❑No ❑**Yes**, List_____
2. **Do you take** any Medications? ❑No ❑**Yes**,....If yes list drug or reason_____
_____
3. **Do you have** any of the following Diseases? ❑No ❑**Yes,**.....If yes circle or list disease STD Hepatitis HIV Syphilis Lyme disease
4. **List** any EYE or Major surgeries you have had. **RK**_____Year **Lasik**_____Year **Cataract** _____ Year Other_____
5. **List** any other major illness you have had or presently have_____
6. When was your LAST Eye Exam? _____Yr _____Months **When** was your LAST **Physical** Exam? _____Yr _____Months

Social History

1. Do you use **Tobacco** products? ❑No ❑**Yes** _____Years _____Packs/Day
2. Do you drink **Alcohol?** ❑No ❑**Yes** _____Drinks per Day
3. Do you use **Narcotics?** ❑No ❑**Yes** _____Type (ie Cocaine, morphine)

Family History and Ocular History

Do any family members have any of the following conditions? (If yes, list relationship to you). If unknown or none check this box ❑**None**

| | | Family Member | | | Family Member |
|---|---|---|---|---|---|
| ❑ Blindness | ❑Self | _____ | ❑ Corneal problem | ❑Self | _____ |
| ❑ Cataracts | ❑Self | _____ | ❑ Lazy eye | ❑Self | _____ |
| ❑ Glaucoma | ❑Self | _____ | ❑ Diabetes | | _____ |
| ❑ Macular Degeneration | ❑Self | _____ | ❑ Heart Disease | | _____ |
| ❑ Retinal Detachment | ❑Self | _____ | ❑ Cancer | | _____ |

**Any Question left BLANK will be assumed to be Negative or Normal**

**I, the patient, acknowledge the above Medical History is accurate and complete**

**Note:** Please note the AARP Website is incorrect "We DO NOT provide Discounts to AARP Members" Our office Opted out of this program

**Patient Signature** (or Guardian if under 18 yr old)_____

**Change of address? YES NO**

# Arcadia Eye Care

## Optical Policies:

We accept prescriptions from other offices, but we are not responsible for rechecks associated with prescriptions done from an outside office. We unfortunately can't offer refunds on professional services or goods, including prescriptions lenses, frames, sunglasses, or open boxes of contacts. Store credit or in store exchanges will be given on any unworn non-prescription frames and sunglasses. No exchanges or refunds on open boxes of contacts.

Every pair of eyeglasses ordered through our labs at Arcadia Eye Care is a custom made order, designed specifically for each individual patient. Therefore it is not in our lab's policy to refund any products that are not resalable or returnable by the manufacturer.

Arcadia Eye Care will honor a prescription change made by the Doctor for 30 days following the original order. In an event that a patient can't adapt to a pair of prescription Progressive eye glasses within 30 days, Arcadia Eye Care will remake the glasses one time into a Standard Bifocal at no additional charge to the patient and no refund will be given for the price difference in materials.

Please note that warranties are available only as the manufactures policies permit, so our labs and Arcadia Eye Care do not have the ability to change or make exceptions. Our labs offer a 1 year scratch warranty for patients who ordered an anti-reflective coating with scratch guard on the lenses.

We would be happy to have you use your own frame for your glasses prescription, but unfortunately, we do not know the integrity of your frames and we are not responsible for lost, broken, or damaged frames.

Many insurance companies require us to use specific labs and the usual turnaround time for glasses is between 7 to 10 business days, with the exception of holidays. Saturday and Sunday are not considered as business days.

I hereby acknowledge that I have read and understand the above information.

_____ _____

**Patient Name (Print)** **Date**

_____

**Patient Signature**

# ADDITIONAL TESTS

In addition to your general eye exam, there are three tests that are recommended by the doctors for optimal eye health assessment. Please take a moment to read the following:

**DILATING THE EYE** – eye drops administered to enlarge the pupil and improve the doctor's view inside of the eye.

This allows the doctor to perform a more thorough examination of the structures of the eye including the retina, optic nerve and blood vessels. This is a very important part of your preventative eye care; this simple procedure allows the doctor to see substantially better inside of the eye. In fact, some systemic diseases such as hypertension and diabetes are first discovered during the dilated eye exam as well as some even more serious problems such as vascular emboli (strokes). We recommend all patients have their eyes dilated on their first exam and every 12 to 24 months thereafter. Patients with certain complaints or systemic problems require dilation more often (dilation can be performed at a later appointment if need be). We also provide free disposable sun glasses, for you may experience some light sensitivity following the procedure.

The additional fee for this recommended procedure is **$15.00**

**VISUAL FIELD SCREENING ANALYSIS** – advanced neurological testing of the eyes and visual pathways.

VIRTUALLY ALL OF THE MAJOR CAUSES OF BLINDNESS IN THE UNITED STATES CAN BE DETECTED BY CHANGES IN THE VISUAL FIELD. This computerized instrument checks the neurology of the eyes by analyzing the central and peripheral areas of vision for slight defects or depressions in visual function. Early detection of these depressions allows early diagnosis and early treatment of diseases. This instrument aids in detecting glaucoma, retinal disease, and such neurological diseases as brain tumors, MS, and optic nerve disease.

The additional fee for this recommended procedure is **$15.00**

**DIGITAL RETINAL IMAGING** – "A picture is worth a thousand words."

A new highly sophisticated digital camera enables us to provide a more thorough analysis of the retina. The photos can be used as a reference to monitor any changes in the eye from one exam to another. Photo documentation is painless as nothing touches the eye and does not usually require the eyes to be dilated. This test is strongly recommended for all patients as a record of reference, but is especially important for those with a family history of diabetes, high blood pressure, high cholesterol, glaucoma, or retinal disease.

The additional fee for this recommended procedure is **$22.00**

| **WHAT EVER IS RECOMMENDED BY THE DOCTOR** | **YES** | |
|---|---|---|
| **Would you like to have your eyes DILATED today?** | **YES** | **NO** |
| **Would you like to have the VISUAL FIELD TESTING today?** | **YES** | **NO** |
| **Would you like to have the DIGITAL RETINAL IMAGING today?** | **YES** | **NO** |

**INITALS:** _____