Child Patient Information

Patient's Name_____ Date of Birth_____

Address_____ Name used or Nickname_____

City_____ State_____ Zip_____

Home Phone_____ Preferred Phone_____

Email_____ Pediatrician_____

School Name_____ Grade_____

Father's Name_____ Date of Birth_____

Employer_____ Work/Cell Phone_____

Mother's Name_____ Date of Birth_____

Employer_____ Work/Cell Phone_____

Is your child having any problems in school with: (circle all that apply) Reading Writing Math Other_____

Has your child ever had a problem:Recognizing colors:_____ Recognizing numbers:_____

Recognizing letters:_____ Letter/Word Reversals:_____ Eye strain while reading:____

Eye Rubbing while reading:_____ Headaches while reading:_____ Reading Comprehension_____

Special class for any subject:_____ Which ones:_____ Repeated grade:_____

Has your child: Ever been patched:_____ Problem with an eye turn:_____

Covered an eye while reading:_____ Wear: Glasses_____Contacts:_____

Is there anything else we should know about your child?_____

_____

_____

Acknowledgment of Receipt of Notice of Privacy Practices

Arizona's Vision
Dr. Mark J. Page & Associates
15215 S 48th St. Suite 180
Phoenix, AZ 85044

Patient Name: _____

Patient Number: _____ Patient Phone Number: _____

Patient Address: _____

Signing this document signifies that you have received a copy of our Notice of Privacy Practices.

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. The ***Notice of Privacy Practices*** you have been given describes these uses and disclosures in detail.

I acknowledge that I have received the *Notice of Privacy Practices* from Arizona's Vision.

_____ _____
Signature Date

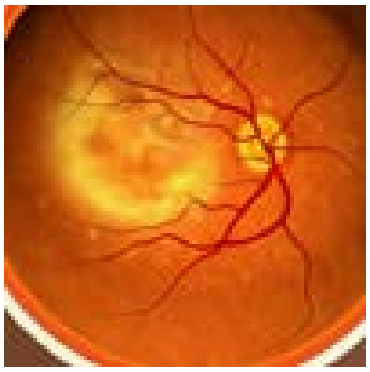
If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

_____ _____
Relationship to Patient Print Name

Source of Authority: _____

Stop Blindness Before It Starts

Join the thousands of others who have used the Optomap to stop blindness before it starts. This is an image of the interior, back portion of the eye called the retina; and, for all intents and purposes, this area is responsible for capturing light and photo-chemically transferring the information to the area of the brain where vision takes place.



You can avoid the blurred vision of dilating drops *and* save 30 minutes today!

Macular Degeneration, Glaucoma, and Diabetes are the leading diseases causing blindness in the US today. To ensure peace of mind we will image your retina to determine your baseline interior eye health. Utilizing this technology, we can be proactive in maintaining your best eye health for your assurance and maintain an accurate historical record. Your fee is $29. The technician will perform this lightning fast and painless procedure during pretesting. **(A PORTION OF EACH OPTOMAP IS DONATED EVERY YEAR TO THE FOUNDATION FOR BLIND CHILDREN.)**

Accept (Sign):_____

I decline Optomap and choose a dilation exam: (Initial)_____

Date: _____