PATIENT LIFESTYLE QUESTIONNAIRE

Patient Name_____ Date_____

1. How many pairs of glasses do you currently use? _____
2. If you wear single vision glasses are they (circle all that apply):
    a. Distance only
    b. Near only (reading)
    c. Computer only
3. Are you interested in or have you ever worn glasses that darken in the sunlight? _____
4. Do you have prescription sunglasses? _____
    a. Are they polarized? _____
5. What kind of glasses do you wear when driving during the day? _____
_____
6. What kind of glasses do you wear when driving at night? _____
_____
7. Are you bothered by glare? _____ If so circle all that apply:
    a. Night Driving
    b. Sunshine
    c. Fluorescent Lights
    d. Computer Screens
8. Do you read small print often? _____
9. Do you perform very fine or close-up work? _____
10. Is safety protection a concern? _____
11. Are you outdoors for extended periods of time? _____
12. How much time do you spend at a computer each day? _____
13. What hobbies/recreational sports do you play? _____
14. Are there any unusual requirements for your work or hobbies? _____
_____
15. What do you like most about your current glasses? _____
_____
16. What do you like least about your current glasses? _____
_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessment and physician certifications.

I received, read and understand the *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient Name: _____

Realtionship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patients signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

VISUAL FIELD SCREENING INFORMATION

We are excited to announce that we are incorporating into our practice a new highly sophisticated, computerized visual field analyzer, the Matrix. Unfortunately routine eye exams do not detect many diseases in their early stages. However, the Matrix detects early Visual Field loss like a "CAT SCAN" specifically for the eye.

The visual field analyzer can detect diseases such as Brain Tumors, Glaucoma, Retinal and Macular degeneration, Optic Nerve Disease, and Retina Disturbances due to vascular problems or medications.

We strongly recommend that all of our patients receive this evaluation. It is especially important for those patients who have a history of high blood pressure, diabetes, headaches, migraines, floaters, retinal problems, high ocular pressures, a high glasses prescription, or have a family member who suffers from Glaucoma or any retinal problems.

This state of the art procedure requires an additional 5 minutes of your time and there is a nominal fee of $20.00 for this screening which is due at the time of service.

Please check the appropriate box below and sign.

☐ YES-I would like a comprehensive examination which includes the Visual Field Screening.

☐ NO-I understand the importance of the Visual Field Screening and that this test would be in my best interest, but at this time, I prefer the general eye examination only. Please do not include the Visual Field Screening.

Signature_____Date_____

Patient Name_____

Please note: While this test is optional for some people, it represents necessary preventative health care for others. It may be required to rule out certain eye diseases. In the latter case, you may be able to submit your bill for the Visual Fields Screening to your medical insurance company for reimbursement.

DRS PHOTGRAPHIC DIAGNOSTIC IMAGER

We are pleased to be able to provide our patients with an advanced digital retina image using the digital retinography system called the **drs**. This image is a high definition photograph of the back of your eye, the retina. This image is a high definition photograph of the back of your eye, the retina. This image helps us to document the health of your retina, compare any changes that may occur over time, diagnose and review pathology which can happen. Many of the diseases seen through this high resolution image are not noticed by the patient until critical structures have been irreparably damaged.

The primary areas of concern are macular degeneration, glaucoma, metastatic tumors, and retinal holes or tears, and their potential. Many systemic diseases such as hypertension, diabetes, thyroid, cancers and hereditary diseases are just a few of the potential visual disturbing complication detected with the **drs** imager.

What you can expect from this procedure:

An eye wellness **drs** high definition image
An in depth view of the retinal surface, where many eye disease first manifest
The ability for the doctor to review the images with you
A permanent record for your medical file, for serial analysis, comparisons and diagnosis
The image is obtained quickly, comfortably and many time with no drops necessary.

Since insurance will only pay for retinal photos after an eye disease is diagnosed, the **drs** examination is an out-of-pocket expense.

Dr. Markle and Associates recommends this procedure for all of his patients and will perform the **drs** image at an additional cost of $45.00 to the basic exam you are receiving today.

Please select the following:
[ ] **I AGREE TO** have my retinal health evaluated using the **drs** imaging system.

[ ] **I DO NOT** wish to have the **drs** image done. I understand that I will still have a thorough eye exam with retinal observation.

We will contact you if there are any findings that are suspect or abnormal.

Patient: _____ Date: _____

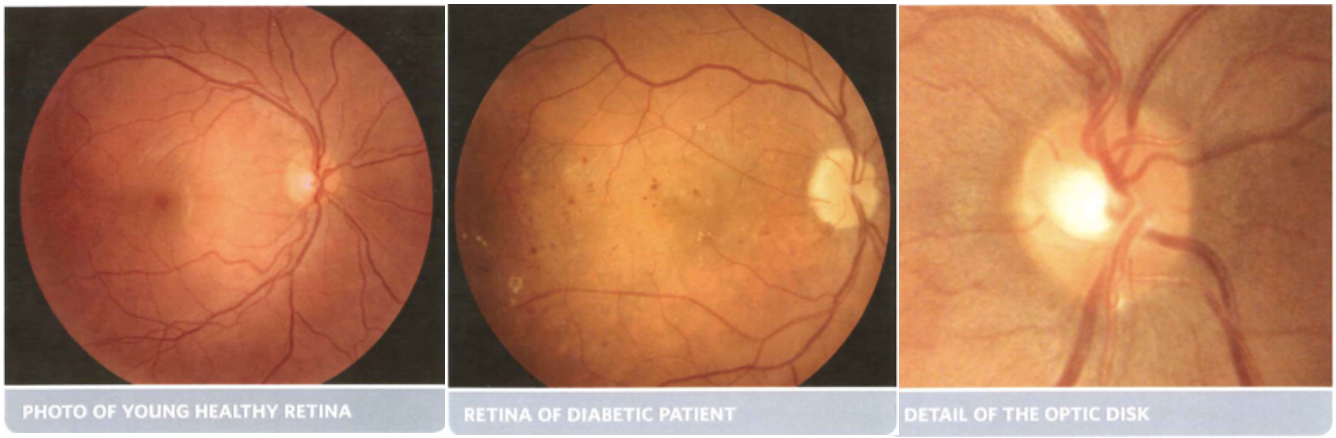

PHOTO OF YOUNG HEALTHY RETINA

RETINA OF DIABETIC PATIENT

DETAIL OF THE OPTIC DISK