Age Related Macular Degeneration & Visual Performance Assessment

Name _____

DOB _____Age _____ Exam Date _____

AMD Risk Factors

(Please check all that apply)

- ☐ Age (Over 50)
- ☐ Family history of Macular Degeneration
- ☐ Smoker (current or prior)
- ☐ Cardiovascular disease
- ☐ Light colored eyes
- ☐ Female
- ☐ < 5 to 9 Servings of fruits and vegetables per day (essential to healthy macular pigment)
- ☐ Outdoor occupations or extensive use of computer, tablet, or smartphone.

Visual Performance Challenges

(Please check all that apply)

- ☐ Night driving difficulties (vision, light glare, etc)
- ☐ Sensitivity to bright light (day or night)
- ☐ Difficulty seeing objects against their background (contrast sensitivity).

FOR OFFICE USE

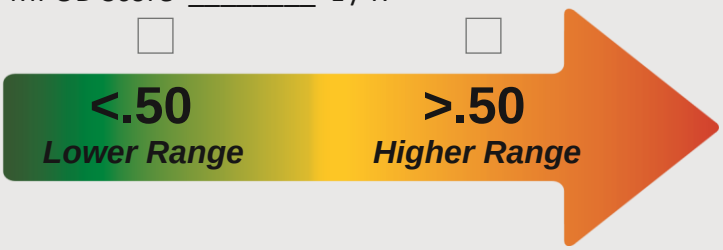
PATIENT RISK DETERMINATION

of AMD Risk Factors _____

# of Visual Performance Factors _____

MPOD Score _____ L / R

☐ ☐



Optomap Retinal Photos

This technology combines retinal photography with computerized imaging to allow instant viewing of the retina and optic nerve in great detail. Both the doctor and the patient see the images on a computer monitor. This method of examining and documenting the retina promotes early diagnosis of abnormal conditions, which could prevent permanent vision loss. An additional benefit of retinal imaging is that we store the pictures permanently to compare them against any future changes.

QuantifEye MPS II

The QuantifEye MPS II Instrument can access a key risk factor for developing age-related macular degeneration (AMD) by measuring the density of pigment present in your macula. Low macular pigment optical density (MPOD) we can better understand your risk for AMD and visual performance challenges.

iWellness Scan

The iWellnessExam™ is a quick, non-invasive scan that allows our doctors to see beneath the surface of your retina. This unique technology can help our doctors detect vision threatening and systemic diseases in their very early stages, when they are most treatable.

☐ I ACCEPT (Please Initial)

_____ Retinal Photo - $39
_____ MPOD - $25
_____ iWellness- $39

_____ All Tests - $64
(**Recommended, Save $39**)

☐ I'd Like More Information

Full Name_____ **DOB**_____ **Age**_____

Please Circle: Mr. Mrs. Ms. Dr. **Gender:** Male Female

Address_____City:_____

State_____ **Zip Code**_____

SSN_____ **Marital Status** Single / Married / Widowed / Divorced

Cell Phone _____**Email**_____

Employer/School_____**Occupation/Grade**_____

Medical Insurance_____**Vision Insurance**_____

How would you prefer to be notified? (Please Circle) Telephone Text Email

HIPAA/Consent to Treat/Consent for Dilation

Notice of Privacy Practices: I have been offered a copy Luckey Eyecare/Dr. Luckey's statement on privacy practices.

Authorization to Release Information: I hereby authorize Luckey Eyecare/Dr. Luckey to release any medical or incidental information that may be necessary for medical benefit or to obtain payment for services. This includes but is not limited to vision plans or medical insurances.

Consent for Treatment: I hereby authorize Luckey Eyecare/Dr. Luckey to administer diagnostic and medical procedures as may be necessary for proper health care.

Patient Signature_____**Date**_____

Declining Dilation: I understand that dilation is recommended by the American Optometric Association to fully assess the health in the back of the eye. By signing this I am **declining** to be dilated and therefore hold Dr. Luckey and Luckey Eyecare harmless as a result.

Patient Signature_____**Date**_____

Consent for Dilation: I understand that a dilated eye examination is recommended by the American Optometric Association to fully assess the health in the back of the eye. Two sets of drop are necessary to achieve dilation and will cause the pupil to enlarge so the doctor can examine the back of the eye. Dilation is of no extra cost to you. It will cause light sensitivity and blurred near vision for a few hours. I consent to have my eyes dilated today and understand the process that will take place.

Patient Signature_____**Date**_____

Contact Lenses

Consent for CL: By my signature, I acknowledge that I have read, understand, and received a copy of the Contact Lens Agreement. I agree that I will adhere to the policies, fees, and clinical requirements of Dr. Luckey's/Luckey Eyecare's contact lens program.

Patient Signature_____**Date**_____