

BROWN OPTOMETRY, INC.

Chart: \_\_\_\_\_

Florissant  
85A Florissant Oaks Shopping Center  
Florissant, MO 63031  
Phone: 314-831-2520

O'Fallon  
2681 Highway K  
O'Fallon, MO 63368  
Phone: 636-978-5555

**Welcome to our office!**

**PATIENT INFORMATION**

Full Name:  Date:

Street Address:

City:  State:  Zip:

Date of Birth:  Age:  Sex:

Home Phone:  Cell Phone:  Work Phone:

Employer and Occupation:

If married, spouse's name:  If child, parent's name:

Who is your medical doctor?

Medical Doctor Phone:  Medical Doctor Fax:

Are you a new patient?  Yes  No If **YES**, when was your last exam?

Where:

What is the reason for this visit?

Please check all that apply for symptoms you are **CURRENTLY** experiencing:

<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Redness	<input type="checkbox"/> Burning	<input type="checkbox"/> Flashes / Floaters
<input type="checkbox"/> Loss of Vision	<input type="checkbox"/> Dryness	<input type="checkbox"/> Eye Pain	<input type="checkbox"/> Loss of Side Vision
<input type="checkbox"/> Double Vision	<input type="checkbox"/> Itching	<input type="checkbox"/> Tearing/Discharge	

Name:

Date:

Check all that apply:

<input type="checkbox"/> Eye Injury	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Autoimmune Disease	<input type="checkbox"/> Fever	<input type="checkbox"/> Pregnant
<input type="checkbox"/> Sleep Apnea	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Muscle Pain	<input type="checkbox"/> Cancer
<input type="checkbox"/> Rosacea	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Muscle Weakness	<input type="checkbox"/> Migraines
<input type="checkbox"/> Asthma	<input type="checkbox"/> General Allergies	<input type="checkbox"/> Joint Pain	<input type="checkbox"/> Thyroid
<input type="checkbox"/> Dry mouth	<input type="checkbox"/> Stroke	<input type="checkbox"/> Skin Rash	<input type="checkbox"/> Multiple Sclerosis
<input type="checkbox"/> HIV	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Upper Respiratory Tract Infection	<input type="checkbox"/> Ankylosing Spondylitis
<input type="checkbox"/> Chlamydia	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Herpes Simplex	<input type="checkbox"/> Cigarettes
<input type="checkbox"/> Tobacco Products	<input type="checkbox"/> Other Substances	<input type="checkbox"/> Alcohol / Beer / Wine	<input type="checkbox"/> Eye Surgery

Are you allergic to any medication? If yes, please list the medications in the box below.

Do you have a family history of?

<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Macular Degeneration	<input type="checkbox"/> Lazy eye
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Please list all current medications and what you are taking them for.

**INSURANCE INFORMATION**

Name:  Date:

Do you have **Routine Vision** insurance?  Yes  No

Name of Insurance:  ID No:

Do you have **Medical** insurance?  Yes  No

Name of Insurance:  ID No:

Name of **primary** cardholder:

Patient relationship to primary cardholder:  Self  Spouse  Child  Other

I hereby authorize payments directly to Brown Optometry all benefits for services rendered. I understand that I am financially responsible for all co-pays, deductibles, co-insurance, and any non-covered services, whether or not paid by insurance, for all services rendered. I agree to pay any and all additional fees associated with collection of any balance past 30 days listed on my account. I authorize use of this signature on all insurance submissions. I understand verification of benefits and eligibility is not a guarantee of payment as stated by my insurance company.

Signature:  Date:

I am aware of Brown Optometry's HIPPA Privacy Notice.

Signature:  Date:

**DILATION**

Dilation requires the use of eye drops to dilate, or widen, the pupils to allow the doctor a greater viewing area of the inside of the eye to assess for any issues such as cataracts or retinal problems such as detachments or bleeding. Driving after dilation is usually not a problem. You will be light sensitive, we provide sunglasses, and your near vision will be blurred for about 4-5 hours depending upon your prescription. There is **no additional charge** for dilation unless another visit is required, in which case a \$60 office visit applies.

**If you are a diabetic, you need to be dilated yearly.**

**Select one and initial.**

I DO want to be dilated:  (please initial)

I DO want to be dilated, but not today:  (please initial) \$60 office visit applies.

I DO NOT want to be dilated:  (please initial)

## VISUAL FIELD

Name:  Date:

An analysis of your visual field is highly recommended for all adult patients, 16 years and older, at the time of your routine eye examination. This test allows your doctor to evaluate not only your side, or peripheral vision, but to assess any complications along the visual pathway through the brain.

Certain progressive health problems, such as glaucoma, brain tumors, strokes, retinal disease can affect the eyes or visual pathways causing a weakness in your field of vision. A visual field can uncover these weakness often long before any signs or symptoms develop.

The visual field is one of the most important tests we can offer for early detection of these types of health conditions. The test generally takes about 10 minutes and dilation of the eyes is **NOT** required.

**The additional fee for this routine screening is \$55 and is not usually covered by your vision care insurance.** However, if certain medical conditions exist or are suspected by your doctor (such as glaucoma, diabetes, retina conditions), then medical insurance will usually pay for the test.

**\* Select one and initial.**

- I DO want this test:  (please initial)
- I DO NOT want this test  (please initial)

**There will be a one-time \$10 charge for your visit today due to COVID-19 PPE products, procedures, and restrictions. Thank you.**