BROWN OPTOMETRY, INC. Chart:_____

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

**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:

| | | | |
|---|---|---|---|
| ☐ Blurred Vision | ☐ Redness | ☐ Burning | ☐ Flashes / Floaters |
| ☐ Loss of Vision | ☐ Dryness | ☐ Eye Pain | ☐ Loss of Side Vision |
| ☐ Double Vision | ☐ Itching | ☐ Tearing/Discharge | |

Name: Date:

Check all that apply:

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

| | | | | |
|---|---|---|---|---|
| ☐ High Blood Pressure | ☐ Diabetes | ☐ Glaucoma | ☐ Macular Degeneration | ☐ Lazy eye |

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: _____

# 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.**

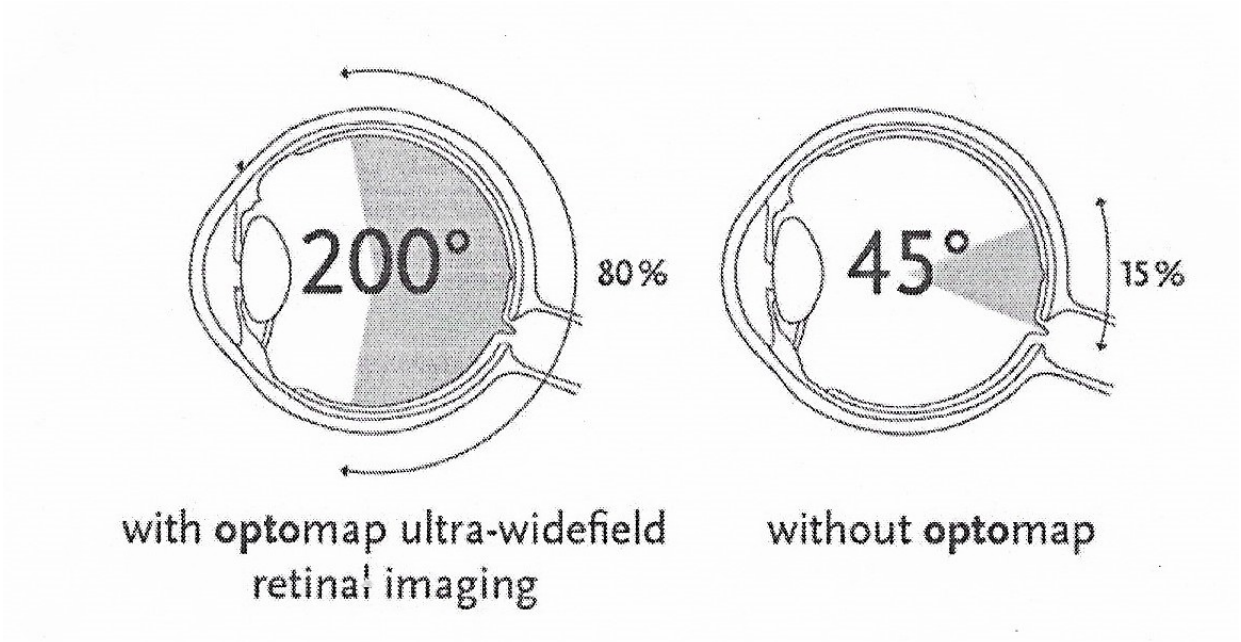
◯ I DO want this test: _____ (please initial)

◯ I DO NOT want this test _____ (please initial)

**OPTOMAP RETINAL SCREENING**

**We pride ourselves on providing our patients with the best possible standard of care.**

**Dr. Brown recommends this test to provide him with the most detailed views of the retina.**




**The screening can detect retinal problems such as macular degeneration, glaucoma, retinal holes, retinal detachments and diabetic retinopathy. For most patients this test can alleviate the need for dilation.**

*** PLEASE INITIAL YOUR CHOICE OF TESTING.**

_____ YES, I would like the Optomap today, $35.

_____ I would like to be dilated today (Rarely necessary if doing Optomap). *Dilation may affect near vision and cause light sensitivity for 4-5 hours.

_____ I do want to be dilated but NOT TODAY ($60 return office visit applies).

_____ I DO NOT want the Optomap or Dilation today.

**EARLY detection is crucial.**

I have read and understand this document:

Sign _____ Date: _____