BROWN OPTOMETRY, INC.

WELCOME TO OUR OFFICE

Marc R. Brown, O.D.

Patient's Full Name:_____ Date: _____

Address:_____City:_____State: _____ Zip Code: _____

E-Mail Address: _____

Date of Birth ___/___/___ Sex: ___ Age: _____ Nickname: _____ SS#: _____

Home Phone: _____Work Phone: _____ Ext._____

Employer:_____ Occupation: _____

If married, spouse's name_____If child, parent's name_____

NEW PATIENTS ONLY: When was your last vision examination? _____ By whom? _____

What is the reason for this visit?_____

☐ Blurred Vision	☐ Redness	☐ Burning	☐ Light Sensitivity or Glare
☐ Loss of Vision	☐ Dryness	☐ Eye Pain	☐ Flashes or Floaters
☐ Double Vision	☐ Itching	☐ Tearing or Discharge	☐ Loss of side vision

HEALTH HISTORY--- Who is your medical doctor?_____

DO YOU HAVE / USE ANY OF THE FOLLOWING: Please check all that apply.

☐ Eye Injury	☐ High blood pressure	☐ Diabetes	☐ High Cholesterol	☐ Use cigarettes
☐ Eye surgery	☐ Medication Allergy	☐ Frequent urination	☐ Autoimmune disease	☐ Use tobacco
☐ Fever	☐ Jaundice	☐ Muscle pain	☐ Pregnant	☐ Alcohol
☐ Sleep Apnea	☐ Chest pain	☐ Muscle weakness	☐ Cancer	☐ Other Substance(s)
☐ Rosacea	☐ General Allergies	☐ Joint pain	☐ Migraine Headaches	☐ HIV
☐ Asthma	☐ Stroke	☐ Skin Rash	☐ Thyroid	☐ Chlamydia
☐ Dry Mouth	☐ Large Volume Blood Loss	☐ Upper Resp Tract Infection	☐ Multiple Sclerosis	☐ Ankylosing spondylitis

DO YOU HAVE A FAMILY HISTORY OF:

☐ High blood pressure	☐ Diabetes	☐ Glaucoma	☐ Macular Degeneration	☐ Lazy Eye

PLEASE LIST ALL MEDICATIONS YOU ARE TAKING: (use reverse side of form if necessary)

_____Taking for_____

_____Taking for_____

INSURANCE INFORMATION

Do you have vision care insurance? Y/N Name of insurance: _____

Name of Primary Cardholder_____ ID#_____ Relationship: 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 charges, whether or not paid by insurance, for all services rendered. I authorize use of this signature on all insurance submissions.

Signature_____Date: _____

I have received a copy of Brown Optometry's HIPPA Privacy Notice dated April 14, 2003.

Signature_____Date: _____

OFFICE USE ONLY: Name: _____ Acct # _____

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VISUAL FIELD ANALYSIS

Visual field analysis is highly recommended for all of our adult patients (age 16 and older) at the time of the routine eye examination. This test allows the Doctor to evaluate the strength of the vision surrounding the central fixation point.

Progressive health problems affecting the eyes or the visual pathway through the brain can cause a weakness in the field of vision. Visual field analysis can uncover weaknesses, often long before any sign or symptom of eye disease becomes apparent.

The visual field screening is one of the most important test that we can offer for the early detection of:

- glaucoma
- retinal and optic nerve disease
- visual pathway disorders, which can include brain tumors, aneurysms, and strokes.

The visual field evaluation generally takes about 10 minutes. Dilation of the eyes is NOT required.

THE ADDITIONAL FEE FOR THIS ROUTINE SCREENING IS $30 AND IS NOT USUALLY COVERED BY YOUR VISION CARE INSURANCE. (However, if certain medical conditions such as glaucoma, diabetes or retinal problems do exist, medical insurance will usually pay for required more complex fields. These fields can range up to $85.

I DO want to include this testing _____ (please initial)

I DO NOT want this testing to be done _____ (please initial)

DILATION

Dilation of the eye (pupils) requires the use of eyedrops, and allows us to view a greater area of the retina (back of the eye). Driving after dilation is not usually a problem (we will provide sunglasses), reading may be a problem for 4-5 hours after dilation, depending on your prescription.

Diabetics should be dilated yearly.

There is NO additional charge for dilation unless another visit is required ($45 office visit applies).

I DO want my eyes dilated today _____ (please initial)

I DO NOT want my eyes dilated today _____ (please initial)

I DO want my eyes dilated, but not today _____ (please initial - $45 office visit applies)