WEST COUNTY
OPHTHALMOLOGY

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Dear New Patient,

Welcome to West County Ophthalmology.

Here are some things to help your first visit with us to go as smoothly as possible.

- **Please arrive 15 minutes prior to your scheduled appointment.**
- **Bring your insurance cards, completed paperwork, a list of your current medications, current eyeglasses and/or contact lenses.**
- ****If you wear contact lenses, please wear them to your visit. Bring the boxes or contact lens prescription with you. Failure to do so may result in a contact lens re-fitting fee****
- **If you are being seen for a medical reason, your insurance may require that you get a referral from your Primary Care Physician. If we do not receive a referral prior to your visit, you will be asked to reschedule.**
- **If you are being seen for a routine eye exam, verify that you have routine vision benefits.**
- **It is the patient's responsibility to check their own insurance benefits and coverage. We collect all co-pays at the time of service.**
- **If you have been treated by another ophthalmologist or optometrist, please make sure that any records pertaining to your visit be obtained prior to your appointment.**

If you have any questions, please do not hesitate to contact our office. We look forward to seeing you!

Sincerely,

The Staff at West County Ophthalmology

**St. Luke's Hospital**
222 South Woods Mill Rd.
Suite 660 North
Chesterfield, MO 63017
314-878-9902
Fax: 314-878-5112

**St. Luke's Urgent Care Building**
5551 Winghaven Blvd.
Suite 190
O'Fallon, MO 63368
636-695-2550
Fax: 636-695-2551

West County Ophthalmology, Inc. Demographics Verification Form

**Please Update/Correct information in the column on the Right**

| **DEMOGRAPHIC INFORMATION** | **UPDATES / CORRECTIONS** |
|---|---|
| Patient Name: | |
| Mailing Address: | |
| Home Phone: | |
| Cell Phone: | |
| Work Phone: | |
| Date of Birth: | |
| Sex: | |
| Marital Status: | |
| Social Security Number: | |
| Primary Care Physician: | |
| Email: | |
| Select One: White___ Black ____ Hispanic_____ Other: _____ | Language spoken: |
| OK to Leave Message: ☐ **Home** ☐**Cell** ☐**Brief** ☐**Extended** | |
| | |
| **EMERGENCY CONTACT INFORMATION** | **UPDATES / CORRECTIONS** |
| Emergency Contact Name: | |
| Phone Number: | |
| Relationship to Patient: ☐**HIPAA** | |
| | |
| **GUARANTOR/RESPONSIBLE PARTY** | **UPDATES / CORRECTIONS** |
| Name: | |
| Guarantor Address: | |
| Guarantor Date of Birth: | |
| | |
| **PRIMARY INSURANCE INFORMATION** | **UPDATES / CORRECTIONS** |
| Insurance: | |
| Insured's Name: | |
| Insured's Date of Birth: | |
| Social Security Number: | |
| Subscriber Number: | |
| Group Number: | |
| Insured's Rel to Pt: | |
| | |
| **SECONDARY INSURANCE INFORMATION** | **UPDATES / CORRECTIONS** |
| Insurance: | |
| Insured's Name: | |
| Insured's Date of Birth: | |
| Social Security Number: | |
| Subscriber Number: | |
| Group Number: | |
| Insured's Rel To Pt: | |
| | |
| **PHARMACY INFORMATION** | **UPDATES / CORRECTIONS** |
| Pharmacy Name/Location: | |
| Pharmacy Number: | |
| Alternate Pharmacy Name/Location/Phone: | |

**I attest that the above information is correct and authorize release of information acquired in the course of my treatment to any authorized agent for purpose of treatment, payment and healthcare. I will be responsible for payment if I do not notify this office of my current medical/vision insurance at the time of service. I have read West County Ophthalmology's private policy and understand the information contained herein. I hereby allow the clinical staff to view my medication history from external sources.**

_____ **DATE** _____

**Patient Signature (18 and under requires signature of Parent/Guardian )**

_____

**Relationship To Child**

# West County Ophthalmology

**Name:** _____ **Date:** _____

**Occupation:** _____ **Employer:** _____

**CHECK CURRENT EYE SYMPTOMS**

( ) LOSS OR BLURRED VISION
( ) DOUBLE VISION
( ) ITCHING, BURNING OR DISCHARGE
( ) REDNESS
( ) FLASHES/FLOATERS
( ) GLARE/LIGHT SENSITIVITY OR HALOS
( ) EYE PAIN OR SORENESS
( ) INFECTION OF LIDS, STYES
( ) GRITTY FEELING, DRYNESS, OR TEARING

**LIST ALL PRESCRIPTION MEDICATIONS:**

_____
_____
_____
_____
_____
_____

**LIST ALL OVER THE COUNTER MEDICATIONS:**

_____
_____
_____
_____
_____
_____

**LIST ALL EYE DROPS USING:**

_____
_____
_____
_____

**LIST ALLERGY/SENSITIVITY TO MEDICATIONS**

_____
_____
_____
_____

**HAVE YOU EVER BEEN DIAGNOSED WITH?**

**CATARACTS** *Y* *N*
**GLAUCOMA** *Y* *N*
**MACULAR DEGENERATION** *Y* *N*
**DIABETIC RETINOPATHY** *Y* *N*
**CROSSED/LAZY EYE** *Y* *N*

**LIST ALL SURGERIES AND THE YEAR:**

_____
_____
_____
_____

**SOCIAL HISTORY**

**DO YOU SMOKE:** *Y* *N* **HOW MUCH** _____ **FORMER** _____ **YEAR QUIT** _____
**DO YOU DRINK?** *Y* *N* **HOW FREQUENTLY** _____
**ARE YOU PREGNANT?** *Y* *N*

**HAVE YOU EVER WORN OR CURRENTLY WEAR CONTACT LENSES?** *Y* *N*
**IF YOU WEAR CONTACT LENSES, LIST BRAND:** _____

SEE REVERSE SIDE

**MEDICAL HISTORY - CHECK IF YOU HAVE OR ARE TAKING MEDICATIONS FOR:**

**CONSTITUTIONAL:**
( ) WEIGHT GAIN ( ) WEIGHT LOSS ( ) FEVER/CHILLS

**ENT:**
( ) NOSE/SINUS PROBLEM ( ) HEARING LOSS ( ) THROAT/SWALLOWING PROBLEM

**CARDIOLOGY:**
( ) CHEST PAIN/ANGINA ( ) HIGH BLOOD PRESSURE ( ) HEART CONDITION

**RESPIRATORY:**
( ) SHORTNESS OF BREATH ( ) EMPHYSEMA ( ) ASTHMA

**GASTROENTEROLOGY:**
( ) ULCER ( ) HEARTBURN/REFLUX ( ) LIVER CONDITION ( ) INTESTINAL/BOWEL PROBLEM

**UROLOGY:**
( ) LOSS OF BLADDER CONTROL ( ) DIFFICULTY URINATING ( ) KIDNEY DISORDER

**DERMATOLOGY:**
( )RASH ( )SKIN CONDITION ( )SKIN CANCER

**MUSCULOSKELETAL:**
( ) JOINT PAIN/SWELLING ( ) ORTHOPEDIC PROBLEM

**NEUROLOGY:**
( ) FREQUENT HEADACHES ( ) MIGRAINES ( ) OTHER NEUROLOGIC CONDITION

**HEMATOLOGIC:**
( ) BLEEDING/BRUISING PROBLEM ( ) ANEMIA ( ) DIABETES ( ) CANCER
( ) HIGH CHOLESTEROL

**HORMONAL:**
( ) THYROID CONDITION

**PSYCHOLOGY:**
( ) DEPRESSION ( ) ANXIETY ( ) SLEEP DISTURBANCE ( ) DEMENTIA ( ) ALZHEIMERS

**ALL OTHER** _____

**FAMILY HISTORY: (PLEASE CHECK ALL THAT APPLY)**

| | GLAUCOMA | DIABETES | MACULAR DEGENERATION | RETINA DETACHMENT | HIGH BLOOD PRESSURE | HEART DISEASE | STROKE | CANCER |
|---|---|---|---|---|---|---|---|---|
| MOTHER | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] |
| FATHER | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] |
| SIBLINGS | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] |
| CHILDREN | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] |
| MATERNAL GRANDMOTHER | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] |
| MATERNAL GRANDFATHER | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] |
| PATERNAL GRANDMOTHER | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] |
| PATERNAL GRANDFATHER | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] |
| MATERNAL AUNT | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] |
| MATERNAL UNCLE | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] |
| PATERNAL AUNT | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] |
| PATERNAL UNCLE | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] |