Whitney B. Brothers, M.D.
Farheen Kazi Raja, M.D.
Scott G. Sagett, M.D.
Steven M. Shields, M.D., F.A.C.S.
Stephen G. Slocum, M.D., F.A.C.S.

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.

- 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.

- Check your medical insurance **very** carefully. If you are being seen for a medical reason, your insurance may require that you get an authorization from your Primary Care Physician. If you are being seen for a routine eye exam, check your insurance to see if you have routine vision benefits. **In order for you to maximize your benefits it is very important for this information to be obtained prior to your visit.**

- Please verify the correct PCP is listed on your card. If the PCP listed is not correct, please contact your insurance as soon as possible **prior** to your visit. Your insurance may also require a referral and the referral must be from the PCP listed on your insurance card. Please obtain the referral before your visit. If we do NOT receive a referral prior to your visit, you will be not seen.

- Please remember to bring your current eyeglasses and/or contact lenses.

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 ______________________

PLEASE LIST ALL Rx & OVER THE COUNTER MEDICATION

____

____

____

____

____

____

ALLERGY / SENSITIVITY TO MEDS

____

____

CIRCLE CURRENT EYE SYMPTOMS:

LOSS OF VISION/BLURRED VISION

FLOATERS/FLASHES

DISCOMFORT/REDNESS

EYE INJURY: YES____ NO____

HAVE YOU EVER BEEN DIAGNOSED WITH?

CATARACT : YES______NO______

GLAUCOMA : YES______NO______

MACULAR DEGENERATION: YES______NO______

DIABETIC RETINOPATHY: YES______NO______

CROSSED EYE / LAZY EYE: YES______NO______

LIST ALL SURGERIES YOU HAVE EVER HAD:

____

____

____

____

____

DO ANY BLOOD RELATIVES HAVE/HAD?

(PLEASE CIRCLE WHETHER MATERNAL OR PATERNAL RELATIVE)

( ) GLAUCOMA (WHO?) ______________________________ MATERNAL/PATERNAL

( ) DIABETES (WHO?) ______________________________ MATERNAL/PATERNAL

( ) MACULAR DEGENERATION (WHO?)______________________ MATERNAL/PATERNAL

( ) RETINAL DISEASE (WHO?)___________________________ MATERNAL/PATERNAL

( ) CROSSED EYE/LAZY EYE (WHO?)______________________ MATERNAL/PATERNAL

( ) HEART DISEASE (WHO?)_____________________________ MATERNAL/PATERNAL

( ) HIGH BLOOD PRESSURE

SOCIAL HISTORY

DO YOU SMOKE? YES____NO______ FORMER______________ ARE YOU PREGNANT? YES_____NO_____

DO YOU DRINK ALCOHOL? YES_____NO_____

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

FEVER_____CHILLS______WEIGHT LOSS_______WEIGHT GAIN_______HORMONES______

HEARING LOSS_____NOSE/SINUS PROBLEM______THROAT/SWALLOWING PROBLEM______

HIGH BLOOD PRESSURE_____ANGINA/CHEST PAIN_____HEART CONDITION______

SHORTNESS OF BREATH_____EMPHYSEMA______ASTHMA______

HEARTBURN/REFLUX_____ULCER_____LIVER CONDITION______INTESTINAL/BOWEL PROBLEM______

KIDNEY DISORDER_____DIFFICULTY URINATING______LOSS OF BLADDER CONTROL______

RASH_____SKIN CONDITION_____SKIN CANCER______

JOINT PAIN/SWELLING(ARTHRITIS)_____ORTHOPEDIC PROBLEM______

BLEEDING/BRUISING PROBLEM______ANEMIA______CANCER______HIGH CHOLESTEROL______

DIABETES______THYROID CONDITION_______HEADACHES_______MIGRAINES_______

DEPRESSION______ANXIETY______SLEEP DISTURBANCE_______DEMENTIA_______

ALZHEIMERS______NONE OF THE ABOVE______OTHER__________________________