Brigham/Farr West Eye Specialists (New or Est		
PATIENT NAME:	DOB:/	
REASON FOR YOUR VISIT TODAY:		
(Check all that apply)		
Vision/Routine Eye Exam Cataracts	Other:	Diabetic Eye Exam
Glaucoma		
	New/Updated Glasses Rx	
	New/Updated Contacts Rx Blurred Distance Visio	n
Interested in LASIK Blurred Near Vision		
CURRENT EYE SYMPTOMS:		
(Check all that apply)		
Blurred Vision Distance Floaters/Spots	_ Loss of Central Vison	
Blurred Vision Near Fluctuating Vision	Loss of Side Vision	
Burning Glare Loss of Vision		
Distorted Vision Headaches Mucous		
Double Vision Infection Redness		
Dryness Itching Sandy/Gritty Feeling		
Watering Light sensitivity C	Other:	_ Eye Pain/Soreness Styes
hoping this explanation will help eliminate any insurance will depend not only upon what you there are vision plans that do not cover medica why we ask to have both your vision and your Routine Vision Care: A routine vision exam or "wellness exam" takes routine exam there will be no symptoms except doctor will screen your eyes for disease and find	s place when you have an eye examination without a of the for visual changes that can be corrected with glasse and no medical problems. Glasses and contact lens pre	m will be submitted to your examination. Remember ver routine eye care which is a medical problem. Under a es or contact lenses. The escriptions may be updated. If
	ronic medical eye or systemic condition you may not	be eligible for a routine eye
examination.		
Medical Eye Examination:		and the standard from the stan
•	on whenever a patient is being evaluated, followed, coms can be given by the patient or found during the edical insurance include but are not limited to:	
	ed Eye Pressure, Narrow Angles, Choroidal Nevus, Macular	=
	t Lens Intolerance, Lattice Degeneration, Amblyopia(Lazy E	
	bility to know and understand your insurance comp	
	ppointment as you will be billed as the responsible	
	t. If you have any questions, please call the number	on the back of your
insurance card or ask a staff member. Thank y	ou for your cooperation.	
SIGNATURE:	DATE:/ R	elationship to patient:

(circle) SELF PARENT/GUARDIAN SPOUSE REPRESENTATIVE/POA OTHER