SURE VISION℠ Eye Centers

Thank you for trusting SureVision with your eye care needs! Part of being able to take good care of our patients includes making sure we have current information on file. We ask that all of our patients complete this paperwork once a year.

- **Return the completed forms at least 10 days prior to your appointment.**
- **Use the enclosed self-addressed stamped envelope, fax to (314) 838-9536 or e-mail to medicalrecords@surevision.us.**
- **Include a full list of the medications you are currently taking.**
- **Bring all medical and vision insurance cards plus a photo ID to your appointment.**
- **Be sure we receive a referral from your primary care doctor at least two days prior to your appointment if your insurance requires it or your appointment will need to be rescheduled.**
- **Payment at the time of your appointment as explained below.**

If you're unsure if a referral is required, call your insurance company to inquire about it at least four days prior to your appointment date. It sometimes takes 3 or 4 days to obtain referrals.

We require payment of all estimated patient expenses when you arrive for your appointment and check in at the front desk. This includes co-payments plus any deductible you might owe. Our staff confirms insurance benefits prior to your visit. They will give you an estimate of how much needs to be paid when you are called to be reminded of your appointment. That amount will be collected prior to seeing the doctor. We accept cash, checks, MasterCard, Visa, Discover, American Express, Apple Pay, Samsung Pay & Android Pay. As well, we offer Care Credit patient financing.

If you have any questions or if you need to reschedule your appointment for any reason, please call one of our offices at the numbers listed below. We are looking forward to seeing you!

Appointment Date_____ Time_____ Doctor_____

☐ 7934 North Lindbergh Blvd., Hazelwood, MO 63042	(314) 921-2020	(866) 305-2044
☐ 12101 Woodcrest Exec Dr.– Ste. 150, Creve Coeur, MO 63141	(314) 863-9966	(866) 305-2044
☐ 1 Professional Dr.– Ste. 260, Alton, IL 62002	(618) 465-2020	(866) 443-6192
☐ 1 Park Place, Belleville, IL 62226	(314) 921-2020	(866) 305-2044

Vision like you've never seen before.℠

SURE VISION Eye Centers

(*Office Use Only*) MRN: _____

NAME		TODAY'S DATE
STREET ADDRESS	APT. #	SOCIAL SECURITY #
CITY, STATE, ZIP		

RACE
☐ AMERICAN INDIAN
☐ ALASKAN NATIVE ☐ BLACK OR AFRICAN AMERICAN
☐ WHITE ☐ DECLINE
☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER

SPECIAL NEEDS
☐ WHEELCHAIR
☐ HEARING IMPAIRED ☐ WALKER
☐ TRANSLATOR ☐ OTHER

PREFERRED LANGUAGE	BIRTH DATE	AGE	ETHNIC ORIGIN	SEX
			☐ HISPANIC OR LATINO ☐ NON- HISPANIC OR LATINO ☐ DECLINE	☐ M ☐ F

CELL PHONE	HOME PHONE	WORK PHONE

PREFERRED METHOD OF CONTACT	E-MAIL ADDRESS
☐ CELL PHONE ☐ HOME PHONE ☐ E-MAIL	
EMPLOYER NAME/ADDRESS	POSITION/DEPARTMENT
SPOUSE'S NAME	MARITAL STATUS ☐ S ☐ M ☐ D ☐ W
EMERGENCY CONTACT NAME	EMERGENCY CONTACT PHONE NUMBER

PRIMARY INSURED

NAME_____

BIRTH DATE _____

RELATIONSHIP TO PATIENT

☐ SELF ☐ PARENT
☐ SPOUSE ☐ OTHER

WHO MAY WE THANK FOR TELLING YOU ABOUT OUR PRACTICE?

NAME_____

PHONE_____

☐ FRIEND/FAMILY ☐ NEWSPAPER
☐ M.D. ☐ RADIO
☐ OPTOMETRIST ☐ TELEVISION
☐ YELLOW PAGES ☐ OTHER

STREET ADDRESS	CITY	STATE	ZIP CODE

PRIMARY CARE DOCTOR	PHONE ( ) -

STREET ADDRESS	CITY	STATE	ZIP CODE

Continued on back ➔

Agreement of Responsibility

I understand that professional services are rendered to the patient and the patient is responsible for charges incurred for these services. Payment for annual deductibles and co-insurance may be collected at the time of service. I understand that I am financially responsible for charges not covered by my insurance company.

Consent to Treat

I voluntarily consent to such care and treatment as prescribed by the physician as is necessary in his/her medical judgment.

Release of Information/Assignment of Benefits

I authorize use of this form on all my insurance submissions and authorize release of information needed to process a claim to all my insurance companies. I permit a copy of this authorization to be used in place of the original. I authorize the provider to act as my agent in helping me obtain payment from my insurance companies. I understand the provider does not accept responsibility for collecting my insurance claims or for negotiating a settlement on disputed claims. I assign all rights and claims for reimbursement of expenses allowable under my insurance plan and authorize payment directly to the provider for services rendered. I understand I will receive a monthly statement for any balance due by me.

This Agreement is in effect until revoked in writing by the patient.

Signature: _____ Date: _____/_____/_____

Medicare Authorization Medicare No. _____

I request payment of authorized Medicare benefits be made on my behalf to SureVision Eye Centers – Midwest, LLC for any services furnished me by that physician/supplier. I authorize the holder of medical information about me to release to Medicare and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes the release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance and the uncovered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Medigap Authorization Insurance Co._____

Policy No._____

Fill out if you have a Medigap insurance policy for which you wish to assign benefits. A Medigap or Medicare Supplemental policy is a health insurance policy or other health benefit plan, offered by a private company, to those entitled to Medicare benefits. It is designed to pay certain costs that Medicare does not pay. By law, this excludes a policy or plan offered by an employer to employees or former employees, as well as a policy or plan offered by a labor organization to members or former members.

Name_____Birthdate_____MRN_____
(office use only)

Referring Doctor_____

Address_____

Phone _____

Provide names & phone numbers of the doctors for the following if they apply:

Rheumatologist_____

Endocrinologist_____

Cardiologist_____

Retina Specialist_____

Oncologist_____

Do you wear glasses? Y N
Do you wear contact lenses? Y N

If yes, type_____
Name of doctor who fit CLs_____

Do you smoke? Y N

If yes, how much?_____ how long?_____

Recreational drug use? Y N

Needle use? Y N

Alcohol consumption? Y N

If yes, amount?_____frequency?_____

Caffeine consumption? Y N

If yes, amount?_____frequency?_____

Do you have any of the following allergies?
Sulfa Y N
Latex Y N

Other medication allergies?_____

_____

_____

Reaction to topical anesthesia? Y N
Reaction to local anesthesia? Y N
Have you had MRSA? Y N
Do you use portable oxygen? Y N

Do you use a wheelchair? Y N
If yes, can you transfer in and out with minimal assistance? Y N

Medical History
(Check if you currently or previously have had.)

___ Seasonal allergies
___ Hypertension
___ High cholesterol
___ Heart disease
If yes, explain _____
___ Heart attack / Stroke (please circle)
If yes, when_____
___ Seizures
___ Lung disease
If yes, explain_____
___ Diabetes
If yes, Type 1?_____ Type 2?_____
"Pre diabetes"?_____
Insulin? ____ oral medication? ____ diet controlled? ____ how long? _____
___ Bowel disease
If yes, explain _____
___ GERD
___ Cancer
If yes, explain_____
Undergoing chemo or radiation? Y N
___ Arthritis – Type _____
___ Sjogrens syndrome
___ Hepatitis (please circle) Type A B C
___ Liver disease
___ HIV/AIDS
___ Thyroid disease
If yes, explain_____
___ Lupus
___ Migraine headaches
___ Anxiety
___ Alzheimer's
___ Dementia
___ Depression
___ Myasthenia Gravis
___ Enlarged prostate
If yes, do you take Hytrin___Terazosin___ or Flomax___?
___ Rosacea
___ Pituitary tumor
___ Kidney disease – ever been on dialysis?
If yes, explain_____
___ Other_____

_____

Do you have a <u>family</u> history of any of the following? **(If yes, check & note family member.)**

___Glaucoma _____
___Macular degeneration _____
___Diabetes _____
___Retinal detachment _____
___Corneal disease _____

Name_____Birthdate_____MRN_____
(office use only)

Local Pharmacy_____

Address _____

Phone _____

Mail Order_____

Medications

Please **list (or attach a list)** of each medication you are taking including the dosage. Please include any over-the-counter medications, nutritional supplements and eye drops. **Please also bring list to your appointment.**

_____

_____

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_____

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_____

Do you give us your permission to contact your pharmacy for a list of your medications?

Y N

Eye History

(Check if you currently or previously have had.)

____Cataracts
____Glaucoma
____Cornea disease
____Macular Degeneration
____Retinal detachment
____Diabetic retinopathy
____Double vision
____Dry Eye
____Lazy Eye (Amblyopia)
____Crossed eyes (Strabismus)
____Eye Injury
____Corneal ulcer
____Eye infection

(Check if you have had any of the following procedures & circle which eye, please.)

____Refractive surgery	R	L
____Cataract surgery	R	L
____Corneal transplant	R	L
____Muscle surgery	R	L
____After cataract laser	R	L
____Glaucoma laser/tube placement	R	L
____Eyelid surgery	R	L

**If your procedure was performed by a doctor not at our practice, please provide doctor's name and dates below.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Patient Signature_____ Date_____ Tech:_____