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 ☐ HISPANIC OR LATINO ☐ NON- HISPANIC OR LATINO ☐ DECLINE	SEX ☐ M ☐ F

CELL PHONE	HOME PHONE	WORK PHONE

PREFERRED METHOD OF CONTACT ☐ CELL PHONE ☐ HOME PHONE ☐ E-MAIL	E-MAIL ADDRESS
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 family 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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____
____

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:__________

SURE VISION Eye Centers

(*Office Use Only*) MRN: ______________________

PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.
By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent.

This Consent was signed by: ____

Printed Name – Patient or Representative

Relationship to Patient (if other than patient): ________________________________

Date:________/________/________ Witnessed by: ______________________________

Printed Name – Patient or Representative

I agree to have my health information disclosed to the following person(s):

______________________________	______________________________
Name	Relationship to Patient
______________________________	______________________________
Name	Relationship to Patient