



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 _____

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

Vision like you've never seen before.sm

NAME		TODAY'S DATE	
STREET ADDRESS		APT. #	SOCIAL SECURITY #
CITY, STATE, ZIP			
RACE <input type="checkbox"/> ALASKAN NATIVE <input type="checkbox"/> WHITE <input type="checkbox"/> NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER		<input type="checkbox"/> AMERICAN INDIAN <input type="checkbox"/> BLACK OR AFRICAN AMERICAN <input type="checkbox"/> DECLINE	
SPECIAL NEEDS <input type="checkbox"/> HEARING IMPAIRED <input type="checkbox"/> TRANSLATOR		<input type="checkbox"/> WHEELCHAIR <input type="checkbox"/> WALKER <input type="checkbox"/> OTHER	
PREFERRED LANGUAGE	BIRTH DATE	AGE	ETHNIC ORIGIN <input type="checkbox"/> HISPANIC OR LATINO <input type="checkbox"/> NON-HISPANIC OR LATINO <input type="checkbox"/> DECLINE
		SEX <input type="checkbox"/> M <input type="checkbox"/> F	
CELL PHONE	HOME PHONE	WORK PHONE	
PREFERRED METHOD OF CONTACT <input type="checkbox"/> CELL PHONE <input type="checkbox"/> HOME PHONE <input type="checkbox"/> E-MAIL		E-MAIL ADDRESS	
EMPLOYER NAME/ADDRESS		POSITION/DEPARTMENT	
SPOUSE'S NAME		MARITAL STATUS <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W	
EMERGENCY CONTACT NAME		EMERGENCY CONTACT PHONE NUMBER	
PRIMARY INSURED NAME _____ BIRTH DATE _____		RELATIONSHIP TO PATIENT <input type="checkbox"/> SELF <input type="checkbox"/> PARENT <input type="checkbox"/> SPOUSE <input type="checkbox"/> OTHER	
WHO MAY WE THANK FOR TELLING YOU ABOUT OUR PRACTICE? NAME _____ PHONE _____		<input type="checkbox"/> FRIEND/FAMILY <input type="checkbox"/> M.D. <input type="checkbox"/> OPTOMETRIST <input type="checkbox"/> YELLOW PAGES <input type="checkbox"/> NEWSPAPER <input type="checkbox"/> RADIO <input type="checkbox"/> TELEVISION <input type="checkbox"/> 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 _____

Have you ever used tobacco? Y N
If yes, type?
____ cigarettes ____ cigar ____ pipe ____ chewing
How many per day? _____ Age started? _____
Age stopped? _____

Recreational drug use? Y N

Alcohol consumption? Y N
If yes, amount? _____ frequency? _____

Caffeine consumption? Y N
If yes, amount? _____ frequency? _____

Have you fallen in the last year? Y N
If yes, were you injured? Y N
Are you considered at risk for falls? Y N
Do you use a wheelchair? Y N
If yes, can you transfer in and out with minimal assistance? Y N

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

**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 _____

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

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.**

(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.

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

Y N

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

Patient Signature _____ Date _____ Tech: _____

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