# EYE SPECIALISTS OF ST CHARLES

DONALD S. LEVY, M.D.

New Patient ☐ Yes ☐ No
Date_____

PATIENT INFORMATION:

Patient Name _____ Birth Date____-_____-____
(Last) (First) (Middle)

Address _____ Social Security # _____-____-_____

City _____ State _____ Zip_____ Phone (____)_____-_____

Alt (____)_____-_____

Relationship to Insured Party: ☐ Self ☐ Spouse ☐ Child ☐ Other Sex: ☐ Male ☐ Female
Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐Widow

Emergency Contact:_____ Phone (____)_____-_____

Referred By :_____

INSURED PARTY:

Name _____ Birth Date____-_____-____
(Last) (First) (Middle)

Address _____ Social Security # _____-____-_____

City _____ State _____ Zip_____ Phone (____)_____-_____

Employer Name _____ Occupation_____

Employer Address _____ Alt (____)_____-_____

PARTY RESPONSIBLE FOR PAYMENT:

Name _____ Birth Date____-_____-____
(Last) (First) (Middle)

Address _____ Social Security # _____-____-_____

City _____ State _____ Zip_____ Phone (____)_____-_____

**PLEASE READ AND SIGN BELOW**

**INSURANCE RELEASE:**
I HEREBY AUTHORIZE THE PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MEDICAL EXAMINATION OR TREATMENT. FOR INSURANCE CLAIM FILING, A PHOTOSTAT OF THE AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL. I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE TO ME OR ON MY BEHALF TO THE PARTY WHO ACCEPTS ASSIGNMENT, FOR ANY SERVICES FURNISHED ME BY THAT SUPPLIER, I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTHCARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

**AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:**
I HEREBY AUTHORIZE THE PHYSICIAN TO RECEIVE DIRECT PAYMENT FOR THE AMOUNT DUE ME IN MY PENDING CLAIM FOR PHYSICIANS SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR CHARGES NOT COVERED BY THIS AUTHORIZATION.

SIGN_____ DATE_____

Name:_____Today's Date:_____

**MEDICAL HISTORY**:
Please list all **medicines** which you currently take including supplements:

1_____ 6_____
2_____ 7_____
3_____ 8_____
4_____ 9_____
5_____ 10_____

ARE YOU ALLERGIC TO ANY MEDICINES/WHICH?_____

| MEDICAL CONDITIONS | PREVIOUS SURGERIES |
|---|---|
| 1: | 1: |
| 2: | 2: |
| 3: | 3: |
| 4: | 4: |
| 5: | 5: |

**SOCIAL HISTORY**:
Current Occupation/ Retired?_____
Do you smoke? Yes-How many packs a day?_____How many years?_____
Used to: How many packs a day? ____How many years? _____
When did you quit? _____
No- Never smoked

Do you use alcohol? If so, how much?

**FAMILY HISTORY**: Please list relatives (F,M,Br,Sist,Son, Daugh,A,U,GM,GF) who had serious medical problems including:

Diabetes
Heart Disease
Stroke
High Blood Pressure
Glaucoma
Macular Degeneration
Lazy Eye
Retinal Disease

PRIMARY CARE PHYSICIAN_____PHONE_____

PHARMACY _____ PHONE_____
PLEASE ADD ANYTHING ELSE YOU FEEL YOUR DOCTOR SHOULD KNOW:

TURN OVER

Name:_____Date:_____

**CIRCLE** any of the symptoms/problems below that apply to you, or **CIRCLE NONE**

| | | |
|---|---|---|
| EYE | NONE | Glasses for distance/near, contacts, eye disease/surgery, glaucoma, lazy eye, temp loss of vision, dry/gritty eyes, tearing, itching, cataracts, light sensitivity, red/pink eyes, distorted vision, lid bumps/redness, pain |
| GENERAL | NONE | Weight change, fevers/chills, night sweats, high cholesterol, lost appetite, fatigue |
| ENT | NONE | Ringing in ears, hearing loss, change in voice, nose bleeds |
| CARDIO-VASCULAR | NONE | Chest pain/angina, heart attack, foot swelling, blood clots, congestive heart failure, angioplasty/stent, high blood pressure |
| LUNGS | NONE | Short of breath, asthma, cough/cough blood, use oxygen |
| STOMACH | NONE | Poor appetite, nausea/vomiting, blood in stool, heartburn, hernia, ulcers, prior abdominal surgery, colitis, yellow skin |
| SKELETAL | NONE | Joint pain/swelling, arthritis, back pain, weakness, muscle pain |
| SKIN | NONE | Rash, moles, history of basal cell/squamous cell tumors |
| NEURO | NONE | Seizures, stroke/TIA, headaches, loss of consciousness |
| ENDOCRINE | NONE | Diabetes, thyroid problems, always tired, no energy |
| BLOOD | NONE | Anemia, lymphoma, bleeding/bruising |
| GENITOURINARY | NONE | Urine infections, pain/frequency urinating, blood in urine, kidney stones, prostate enlargement/surgery |
| BREASTS | NONE | Lump, pain, nipple discharge, |
| ALLERGIES | NONE | Foods, pollen, medicines |
| PSYCH | NONE | Depression, anxiety, other |

Physician use:
I have reviewed the above information with this patient at the time of this visit. All others negative

_____ Date:_____

DR. LEVY

**Eye Specialists of St. Charles, LLC**
**Donald S. Levy, M.D.**

***RECORDS RELEASE***

Date:_____

Please transfer a copy of my records from _____

Phone#_____ Fax #_____ to:

Dr. Donald S. Levy, M.D.

330 First Capitol Dr.
Medical Building 1
Suite 330
St. Charles, MO 63301

Tel: 636-947-3937
Fax: 636-947-9425

Attention: Crystal

_____ _____
Print Patient Name/ Date of birth Signature and Date

_____ _____
Received by: Date Sent:

DONALD S. LEVY, M.D.

EYE SPECIALISTS OF ST. CHARLES
330 FIRST CAPITOL DR. SUITE 330
ST. CHARLES, MO 63301
PHONE: 636-947-3937
FAX: 636-947-9425

I give my permission for Dr. Levy and the office staff to release my medical / account information to the following people:

_____ relationship _____

_____ relationship _____

_____ relationship _____

_____ relationship _____

_____ I decline to release my medical / account information to anyone.

_____ _____
Signature DATE

_____
Please Print Name

**EYE SPECIALISTS OF ST. CHARLES**

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 reviised 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 those 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

Signed by:_____(printed name of patient or representative)_____

Relationship to Patient (if other than patient)_____ Date:_____

In front of _____(printed name of practice representative)

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Office use only:

Eye Specialists Of St. Charles will make a good faith effort to obtain a written acknowledgement of receipt of the Notice provided to the individual. If written acknowledgement is not obtained our practice must document its good faith efforts to obtain such acknowledgement and record the reason why the acknowledgement was not obtained.

Refused to sign [ ] Physically unable to sign [ ]

Other:_____

_____

Employee Signature _____ Date:_____