EYE SPECIALISTS OF ST CHARLES

New Patient ☐ Yes ☐ No
Date_____

DONALD S. LEVY, M.D.

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_____

EYE SPECIALISTS OF ST. CHARLES, LLC

List all **medications** that you take:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

List all **medication allergies**: _____
_____

List all **surgery** you have had: _____
_____ _____
_____ _____

Circle all of the following **medical diseases** that you have now or in the past:
(Add any that are not listed if you need to)
Cataracts Glaucoma Macular degeneration Retinal detachment
Any other eye disease: _____
Stroke Heart attack High Blood Pressure High cholesterol Coronary artery disease
Any other heart disease: _____
Asthma COPD Lung cancer
Any other lung disease: _____
Stomach ulcer Colon cancer Colitis Liver disease
Any other digestive disease: _____
Arthritis Osteoporosis
Any other bone disease: _____
Diabetes Low Thyroid High Thyroid
Kidney Stones Kidney Failure
Prostate Cancer Enlarged Prostate Breast Cancer
Rheumatoid Arthritis Lupus Ankylosing Spondylitis
Any other medical disease: _____

Current Job (or retired): _____

Do you smoke? _____Yes How many a day?_____ For how many years?_____
_____No
_____Used to When did you quit? _____
Do you drink alcohol? _____Yes How much? _____
_____No

Patient's Name: _____ Today's date: _____
Patient's primary physician: _____ Phone: _____
Patient's pharmacy: _____ Phone: _____

Patient's name:_____ Today's date_____

Have any family members (father, mother, brother, sister, or grandparent) had these medical diseases? Please include who had the disease:

Diabetes_____ Heart Disease_____ Stroke_____
High Blood Pressure_____ Glaucoma_____
Macular Degeneration_____

Please circle any of these **symptoms** (problems) that you currently have:

Fever Chills Night sweats Unexplained weight loss
Extreme tiredness Weakness

Wear glasses Blurred vision Eye pain Red eyes
Light sensitive eyes Dry eyes Swollen eyelids

Hearing loss Ringing in ears

Chest pain Shortness of breath Swelling in legs/feet

Nausea/vomiting Heartburn Loss of appetite Yellow skin
Blood in stool

Joint pain Joint swelling Back pain Muscle pain

Skin rash Moles or other skin changes

Seizures Headaches Fainting spells Loss of speaking ability
Weakness on one side

Bleeding Bruising

Kidney stones Pain urinating Blood in urine

Breast pain Breast lumps Discharge from nipples

Depression Anxiety

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)

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:_____