PATIENT INFORMATION **Acct**_____

M/F

Last Name_____ **First Name**_____ **MI**___ **DOB**_____

Street Address_____ **Apt**____ **Social Sec No** _____

City, State, Zip_____ **Home phone** _____ **Cell** _____

Name of Employer _____ **Work phone**_____

Street Address_____ **City, State, Zip**_____

Guarantor/ Insured Information (IF DIFFERENT FROM PATIENT)

Last Name_____ **First Name**_____ **MI**___ **DOB**_____

Relationship to patient: *SPOUSE*_____ *PARENT*_____ *OTHER (please specify)*_____

Street Address_____ **Social Sec No**_____
(If different from above)

City, State, Zip _____ **Home Phone** _____
(If different from above) (If different from above)

Employer _____ **Work phone**_____

Street Address_____ **Cell phone**_____
(If different from above)

City, State, Zip_____

Primary Physician Name_____

Endocrinologist's Name (If applicable) _____

Rheumatologist's Name (If applicable)_____

Review of Systems: Do you have problems in the following areas?

General/Constitutional (fever, unexplained weight loss or gain)----------	Y	N
Ears/Nose/Throat(sinus, cough, dry mouth)----------	Y	N
Cardiovascular (heart disease, vessels, HBP)----------	Y	N
Respiratory (asthma, bronchitis, emphysema0----------	Y	N
Gastrointestinal (ulcers, intestinal disease)----------	Y	N
Genital/Kidney/Bladder (Herpes, Chlamydia)----------	Y	N
Muscles/Bones/Joints (arthritis)----------	Y	N
Skin (acne)----------	Y	N
Neurological (MS, stroke, epilepsy, headache0----------	Y	N
Psychiatric (anxiety, depression, memory loss)----------	Y	N
Blood/Lymph (high cholesterol, anemia, bleeding)----------	Y	N
Allergic/Immunologic (hay fever, Lupus)----------	Y	N
Cancer----------	Y	N
Diabetes----------	Y	N

If **YES** (please circle) Type I Type II
(please circle) Insulin Dependent Non-insulin Dependent

PLEASE TURN THIS PAGE OVER

Please sign and date Consent to Treat and Assignment of Benefits

CONSENT TO TREAT: Please sign only the next available blank line

I consent to and authorize the physicians, and other healthcare providers at St. Charles Eye Center, Inc. to perform appropriate healthcare examinations, treatment, and diagnostic testing or medication administration as deemed medically necessary by their professional judgment. I know that there are some risks with all medical treatments and procedures and I understand that no one can guarantee how well treatments or procedures will work.

Patient signature_____ Date_____

Patient signature_____ Date_____

Patient signature_____ Date_____

Patient signature_____ Date_____

Patient signature_____ Date_____

Patient signature_____ Date_____

ASSIGNMENT OF BENEFITS/PAYMENTS FOR SERVICES:

Please sign only the next available blank line

I authorize payment of any and all benefits to St. Charles Eye Center, Inc. I know that I must pay for any charges for my care that are not covered by my insurance, health plan or government programs. I realize that I must cooperate with St. Charles Eye Center, Inc to get payment for my care. If I have an unpaid bill at St. Charles Eye Center, Inc. any refunds due to me will be put on my unpaid bill. If there is money left over after the bill is paid, I will get a refund from St. Charles Eye Center, Inc.

Patient signature_____ Date_____

Patient signature_____ Date_____

Patient signature_____ Date_____

Patient signature_____ Date_____

Patient signature_____ Date_____

Patient signature_____ Date_____

Please turn this page over

PATIENT AUTHOIZATION TO DISCLOSE
PRIVATE HEALTH INFORMATION

In our effort to keep your health information private, St. Charles Eye Center, Inc. requests your assistance in completing the following information. If you have a medical POA, please give us a copy.

Please identify the name of any member of your household with whom we may speak concerning your medical care.

Spouse_____ Family Member_____

Son/Daughter_____ Friend/Caregiver_____

Please identify the name of any member of your household with whom we may speak concerning your insurance information or bill.

Spouse_____ Family Member_____

Son/Daughter_____ Friend/Caregiver_____

You may notify me or the parties listed above to report test results, medical information, billing, insurance, and/or other information pertaining to me from the St. Charles Eye Center, Inc.

___ Message on home answering machine/voicemail Number_____

___ Message on work voicemail Number _____

___ Message on cell phone Number _____

___ Other:_____ Number _____

I understand and direct that this authorization will remain in effect until it is revoked by me in writing.

Patient Name: _____

Signature: _____ Date: _____

_____ Date _____
Signature of Legal Guardian or Patient Representative (If applicable)

Printed Name and relationship _____

PLEASE TURN THIS PAGE OVER

Dear Patient:

We are happy to provide both routine vision services as well as medical services within the same office visit if you have a medical diagnosis such as diabetes, glaucoma, macular degeneration, cataracts, etc.

The medical testing is not covered under your vision insurance. These services are billed directly to your medical insurance carrier. A few medical insurances will also apply a separate copay for the medical testing.

This would mean that you would have a copay both for the vision insurance AND the medical insurance.

We will ask for the copay for the vision insurance at the time of your visit and if your medical insurance applies a copay, we will bill you for that after they have paid.

We believe this circumstance MAY apply to your situation. Therefore, we will need your written consent to do both vision testing and medical testing today. You certainly have the option of doing these separately and we will schedule another appointment for you if you so choose.

I understand that if I receive a vision test and do not have a separate vision insurance, or make the office aware of my vision insurance, I will be responsible for the refraction (eye exam) fee on my bill.

_____ _____

Patient signature Date

_____ _____

(Patient's guardian or POA if patient Date is unable to give consent)

This page is provided for those who may not carry a medication list.
If you do not take medications, PLEASE LEAVE ENTIRE SHEET BLANK.
If you have a list, please provide it to the receptionist at check in.

Patient Name:	Date of birth:

Medication Name/Mg	Dosage

Thank you for your cooperation. Please bring this form along with any other forms with you to your appointment.
*Please have your insurance cards ready to present to the receptionist when checking in.

Thank you