1384 S. Fifth Street
St. Charles, MO 63301
(636) 946-9242
fax: (636) 946-4903

13025 Olive Street Road
Creve Coeur, MO 63141
(314) 878-8770
fax: (314) 878-5971

1325 G Queens Court
St. Peters, MO 63376
(636) 441-8010
fax: (636) 441-5128

532 Old Smizer Mill Road
Fenton, MO 63026
(636) 305-7110
fax: (636) 305-9509

1155 Wentzville Parkway, Suite 119
Wentzville, MO 63385
(636) 639-9422
fax: (636) 639-6713

Last Name ______________________ First Name ______________________ MI ______ Today's Date ____________

Address ______________________________ City ____________________ State ______ Zip ____________

Work phone (_____) ____________________ Home phone (_____) ________________ SSN _______-______-_________

Cell phone (_____) ____________________ Email Address ____________________________________

DOB ____________ Occupation ______________________ Employer ______________________

Whom may we thank for your referral to our office? ______________________________

Race and Ethnicity:

☐ Unknown ☐ African American ☐ American Indian ☐ Arab ☐ Asian
☐ Caucasian ☐ Hawaiian ☐ Hispanic Latino ☐ Indian ☐ Multiracial

Preferred Language: ____________________

☐ Hispanic or Latino
☐ Not Hispanic or Latino

Gender: Male or Female
Dominant Hand: R or L

Medical Information

What is your general health? ______________________________ Height ____________ Weight ____________

Do you have problems with any of these systems? **(Please circle yes or no.)**

Ears/Nose/Throat	Yes/No	High Blood Pressure	Yes/No	Integumentary(skin)	Yes/No
Neurological	Yes/No	Respiratory	Yes/No	Endocrine/Diabetes	Yes/No
Headaches	Yes/No	Gastrointestinal	Yes/No	Blood/Lymph	Yes/No
Psychiatric	Yes/No	Urinary	Yes/No	Allergic/Immunologic	Yes/No
Cardiovascular	Yes/No	Muscles/Bones	Yes/No	Pregnant	Yes/No
Please explain ______________________________				Nursing	Yes/No

Diabetes Yes/No Type ______________________ Date of diagnosis ______________________

Allergies to medication? Yes/No Which? ______________________ Reactions ______________________

Other health problems ____

Current medication(s) ____ Check if none☐

Have you had any operations? Yes/No Kind? ______________________ When ______________________

Name of family doctor ______________________________ Doctors phone number (_____) ______________

Date of last visit ______________________ Date of last tetanus shot ______________________

Last eyecare provider ______________________ Date of last eye examination ______________________

Preferred Pharmacy ______________________ Location ______________ Phone ______________

Smoking History

☐ Current Every Day Smoker
☐ Current Some Day Smoker
☐ Former Smoker
☐ Never Smoker
☐ Smoker (Current Status Unknown)

Do you drink alcohol? ☐ Yes ☐ No ______________________

Do you use illegal drugs? ☐ Yes ☐ No ______________________

Have you ever been exposed to or infected with: ☐ HIV ☐ Hepatitis

Family History

High blood pressure	Yes/No	Relation ____________	Macular degeneration	Yes/No	Relation ____________
Diabetes Type 1/2	Yes/No	Relation ____________	Retinal detachment	Yes/No	Relation ____________
Cancer	Yes/No	Relation ____________	Cataracts	Yes/No	Relation ____________
Hyper/Hypo Thyroid	Yes/No	Relation ____________	Glaucoma	Yes/No	Relation ____________

Personal Eye Information

Do you have any eye conditions or problems? Yes/No What kind? ______________________________

Have you had any eye operations? Yes/No Type ______________________ Date ____________

Have you had an eye injury? Yes/No Kind ______________________ Date ____________

Do you have glaucoma? Yes/No Cataracts? Yes/No Dry/Red/Gritty eyes? Yes/No

Macular degeneration? Yes/No Retinal detachment? Yes/No Blurred vision? Yes/No

Do you wear glasses? Yes/No Contact lenses? Yes/No Type ______________________

Additional information ____

POS® Reorder # 0611805

ACKNOWLEDGEMENT
OF
NOTICE OF PRIVACY PRACTICES

The law requires that Midwest Eye Associates, Inc. make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

- ☐ I have read or had explained to me Midwest Eye Associates, Inc. Notice of Privacy Practices and agree to continue my care with Midwest Eye Associates, Inc. under said terms.

- ☐ I was given the opportunity to read Midwest Eye Associates, Inc. Notice of Privacy Practices and declined but wish to continue my care with Midwest Eye Associates, Inc. under the terms of Midwest Eye Associates, Inc. privacy policies.

- ☐ I have read or had explained to me Midwest Eye Associates, Inc. Notice of Privacy Practices and do not wish to continue my care with Midwest Eye Associates, Inc. under said terms.

- ☐ The Notice of Privacy Practices could not be read due to the emergent nature of the care or other reason described as
  ____
  ____

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

______________________________ ________________
Patient Date

If you are signing as a personal representative of the patient, please indicate your relationship:

______________________________ ________________
Representative Relationship to Patient

PATIENT FINANCIAL RESPONSIBILITY

I authorize **Midwest Eye Associates, Inc., Drs. Bradley A. Byergo, Jerome L. Becker, Bradley E. Borello, and Seth M. Bachelier,** to apply for benefits on my behalf for any services performed by them. I agree to assign my benefits and request that all payments from my insurance plan(s) be made directly to the above provider(s). I agree to assume responsibility of any unpaid balances not covered by my insurance plan(s), or to assume full responsibility for patient fees if I have no insurance coverage.

Patient Signature:____
If patient is a minor, parent or guardian is required to sign above.

Responsible Party Signature (if different from above):______________________________