MIDWEST EYE ASSOCIATES

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fax: (636) 946-4903

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(314) 878-8770
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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 |
| | | | | Nursing | Yes/No |

Please explain ______________

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, Bradley E. Borello, Seth M. Bachelier, Douglas Huff, and Trista Pabisz** 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):______________________________