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