PATIENT TODAY'S DATE_____

Mr. Miss Ms. Mrs. Dr_____Sex: M F Marital Status: M D S W

Address_____City_____State_____

Zip_____Social Security #_____Date of Birth___/_____/_____Age_____

Home Phone ( )_____Cell Phone ( )_____

Employer_____Work Phone ( )_____

Primary email address_____

Emergency contact_____Phone # ( )_____

Primary Care Doctor_____Office # ( )_____
FIRST AND LAST NAME

Referring Doctor_____Office # ( )_____
FIRST AND LAST NAME

Have we treated other members of your family? Y N If yes, please list_____

SPOUSE OR RESPONSIBLE PARTY

Name_____Relationship to patient_____

Address_____City_____State_____

Zip_____Social Security #_____Date of Birth___/_____/_____Age_____

Home# ( )_____Work# ( )_____Cell/Other# ( )_____

Employer_____Employer Address_____Occupation_____

INSURANCE

Primary Insurance Company Name_____Subscriber Name_____

Subscriber's SS#_____Subscriber's Employer_____

Subscriber's Date of Birth_____Relationship to Patient_____

Secondary Insurance Company Name_____Subscriber Name_____

Subscriber's SS#_____Subscriber's Employer_____

Subscriber's Date of Birth_____Relationship to Patient_____

We have contracts with many health plans to accept an assignment of benefits. We bill the plans that we have an agreement with and we will require you to pay your co-payment at the time of service. If you are in plan for which a referral is required, it is your responsibility to bring a referral with you at the time of service, or have your primary care physician forward the information to us prior to your visit. If you choose not to obtain a referral, you will be financially responsible for all services provided by Dr. Blatt.

Your medical records are protected by HIPAA. Your information is important and confidential. Our policies require that your information be held in strict confidence. If desired, please ask for more information.

Routine vision exams and refractions are not usually covered by insurance with or without a referral. Therefore, payment is due at the time of service. The charge for refraction is $45.00.

I authorize payment of medical benefits to St Louis Eye Care Specialist, LLC for any services provided by Andrew N. Blatt. I understand that I am financially responsible to the provider for charges not covered by my insurance benefit plan. I authorize the release of any medical information necessary to process any insurance claims or as a means of object to the use of my health information but need to do so in writing.

Payment is due upon receipt of statement from our office.

Patients who do not show or cancel appointments with less than 24 hours notice will be charged a $50.00 fee.

Signature of Patient or Guardian_____