PATIENT TODAY'S DATE _____

Name_____ Nickname:_____ Sex: M F

Address_____ City_____ State_____

Zip_____ Date of Birth___/_____/_____ Age_____ Patient's Social Security #_____

Home Phone ( )_____ Primary Email address_____

Emergency contact _____ Phone # ( )_____

Primary Care Doctor_____ Office # ( )_____
FIRST AND LAST NAME

Mother's Name_____ Work #( )_____

Father's Name_____ Work #( )_____

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

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 in 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 M.D. 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.

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

Signature of Patient or Guardian_____