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

12392 Olive Blvd
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

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

Last Name:_____ First Name: _____ MI:_____ Date:_____

Address:_____

Cell Phone Number: (_____) _____ Work Phone Number: (_____) _____

Email:_____

Changes Medical History:_____

Current Meds:_____

_____

Height:_____ Weight: _____

Allergies to Meds: Yes/No Which:_____ Reactions:_____

Primary Care Physician:_____ Location: _____ Phone:_____

Preferred Pharmacy:_____ Location: _____ Phone:_____

Race/Ethnicity:

☐ Unknown ☐ African American ☐ American Indian ☐ Arab ☐ Asian ☐ Hispanic or Latino Gender: Male or Female
☐ Caucasian ☐ Hawaiian ☐ Hispanic Latino ☐ Indian ☐ Multiracial ☐ Not Hispanic or Latino Dominant Hand: R or L

Preferred Language:_____

Smoking:

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

Do Either Apply:

Pregnant Yes No N/A
Nursing Yes No N/A

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. Seth M. Bachelier, Bradley E. Borello, Bradley A. Byergo, 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):_____