Dr. Jason W. Hendrix M.D.
Dr. D. Snow Slade M.D.

St. George EYE CENTER

Chart#

617 E Riverside Dr. Ste 101
St. George UT 84790
Phone: 435-628-4507
Fax: 435-628-3748

PATIENT INFORMATION

Patient Name_____

Date of Birth ___/___/___ **Age**___**Gender M F**

Social Security #_____

Mailing Address_____

City _____**State**____**Zip** _____

Home Phone (____) _____

Cell Phone (____) _____

Email Address _____

Marital Status _____

Preferred Language_____

Race (Required) ☐Caucasian ☐ Native American ☐African American ☐ Asian ☐Other

Ethnicity Hispanic / Non-Hispanic /Declined

Employer _____

Employer Address _____

Employer Phone (____) _____

INSURANCE INFORMATION

Primary Insurance

_____

Subscriber's Name

_____

Subscriber's Date of Birth_____

Secondary insurance

_____

Subscriber's Name_____

Subscriber's Date of Birth_____

RESPONSIBLE PARTY/GUARDIAN

Name _____

Address _____

City _____ State _____Zip _____

Home Phone (____) _____

Date of Birth _____SS# _____

Employer _____

Employer Phone (____) _____

****Emergency contact (name & number)**_____

I authorize the person/persons listed below to receive information regarding my personal health information:

Name: _____ **Relationship to Patient:**_____

_____ _____

Patient Signature (or person authorized to sign for patient) **Date**

SEE REVERSE SIDE

St. George EYE CENTER

MEDICAL INFORMATION RELEASE

I acknowledge that I have been provided a copy of the NOTICE OF PRIVACY PRACTICES of St. George Eye Center (the "clinic") and that the Clinic may release all or portions of my medical record to me, and to people or companies responsible to pay the charges for my care, such as my insurance or health benefits companies, or worker's compensation carriers. I further acknowledge that the Clinic may disclose my patient information to referring or treating from other health care entitles and providers, including but not limited to, copies of lab results, diagnostic test reports, films/images, and other clinic information, request more information, and revoke this authorization, as permitted by the federal privacy regulations and in accordance with the Clinic's privacy policy.

Patient/Responsible Party Signature:_____Date:_____

CONSENT FOR TREATMENT

I hereby consent to the medical treatment, diagnostic and laboratory tests, and other procedures, which the physician(s) may deem advisable in treatment of my case (or as legal guardian for patient). The Clinic will determine the proper disposition of any tissues, parts. Or body fluids consistent with state and federal laws. This agreement will remain in effect until I choose to revoke it in writing.

Patient/Responsible Party Signature:_____Date:_____

CREDIT AND FINANCE CHARGE POLICY AND AGREEMENT

I hereby authorize any benefits due me to be paid directly to the Clinic 1054 E Riverside Dr. Ste 201, St. George UT 84790. I understand and agree that I am financially responsible for all deductible amounts, co-insurance, non-covered services or services deemed as "non-medically necessary" by my third-party insurance carrier. I agree that I am responsible to satisfy any conditions necessary for insurance or health benefits.

A finance charge (1.5% per month/APR 18%) may be added to any amount for which payment has not been received within 60 days from the date of the statement on which the amount first appears. I hereby agree to pay a service charge of $20.00 for each check or other instrument tendered by me but returned to this facility. Additional service charges may be levied for accounts placed with third-party collections agencies, or failure to make necessary co-payments at the time of service.

It is understood and agreed that if I fail to pay this account in accordance with policy, then I will pay all reasonable attorney fees and other costs incurred for collection of this account.

In consideration for medical services rendered, I (we) acknowledge that I (we) have received notice of the Clinic's financial policy and agree to pay for said medical services according to such terms.

Patient/Responsible Party Signature:_____Date:_____

MEDICARE PATIENT AGREEMENT
(Required by Medicare for all Medicare Claims)

_____

Entitlee's Name Medicare Subscriber Number

I hereby request that payment of authorized Medicare benefits be made either to me or on my behalf to ST. GEORGE EYE CENTER, LLC for any services furnished me by that provider. I authorize any holder of medical information about me to release to Center for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

This authorization is in effect until I choose to revoke it in writing.

Signature:_____Date:_____

Employee Signature: _____Date:_____

MEDICALINFORMATION SHEET

Name _____
DOB _____
MRN _____
Hendrix/Slade/Behunin/Smith

Referring Physician: _____

Primary Physician: _____

Have you ever had any of the following? If yes, when?

	Yes	No	When?
Eye Injury			
Glaucoma			
LASIK/RK/PRK (**circle one**)			
Other Eye Surgery (**explain**)_____			
Do You Wear Contact Lenses?			

	Yes	No	When?
Retinal Detachment			
Macular Degeneration			
Blindness			
Other Eye Problems (**explain**)_____			
Lazy Eye			

Have you ever had problems with any of the following? If yes, when?

	Yes	No	When?
Diabetes			
Cancer			
Thyroid disease			
Heart Attack or Stroke			
Seizure Disorder			
High blood pressure			
Prostate Problem			
Sinus Infection			

	Yes	No	When?
Arthritis(Osteo or RA)			
Muscle Disease			
Asthma/Bronchitis (**Circle One**)			
High Cholesterol			
Autoimmune Disorder			
Emphysema/COPD (**Circle One**)			
Tuberculosis			
Anemia/Blood Disorder			

***PLEASE LIST YOUR CURRENT PHARMACY AND LOCATION**_____

List **all** medications you are taking (including eye drops, aspirin, birth control, herbal supplements, vitamins,etc.)

_____

_____

Allergies to medication: _____

Surgeries and approximate year: _____

Do you smoke? Yes / No Are you a former smoker? Yes / No Do you drink alcohol? Yes / No

Please indicate if any of your family(and who)/blood relatives have had any of the following medical conditions:

☐ High blood pressure_____ ☐Diabetes_____ ☐ Retinal detachment_____ ☐ Heart disease_____

☐ Blindness_____ ☐ Macular degeneration _____ ☐ Glaucoma _____ ☐ Lazy eye_____

Updated on:_____ **Patient Signature:**_____

Updated on:_____ **Patient Signature:**_____

Updated on:_____ **Patient Signature:**_____