Paul M. Tesser, MD PhD FACS

Glaucoma Consultants of St. Louis, LLC

Welcome to our practice! You have scheduled an appointment with either Dr. Tesser or Dr. Beatty on _____ @ _____.

We would appreciate you filling out these forms ahead of time to ensure the best quality of service provided to you upon arrival. Bring these forms with you along with your government issued identification and insurance cards to you first appointment. Please DO NOT mail in these forms.

Our office has contracts with a variety of medical insurance plans. Please check with your carrier regarding plan requirements. If your insurance requires an insurance referral from your primary care physician, it is your responsibility to obtain one. Please note: our only location is the St. Luke's location, ensure your primary care physician knows this information.

Some appointments will require a minimum of 1 ½ to 2-hour visit. Please be advised you will be dilated for this visit. Bringing a driver is encouraged but not required. We will provide you disposable sunglasses at the end of your visit.

Should you need to cancel an appointment, we ask that you notify us as far in advanced as possible to provide that time slot to another patient. There is no cancellation or no show fees but we encourage you to keep or reschedule all appointments.

Thank you and we look forward to meeting you!

Sincerely,

Paul M. Tesser, M.D., Ph.D. FACS

Jeremy A. Beatty, O.D., FAAO

224 South Woods Mill Road • Suite 700S • Chesterfield, Missouri 63017
70 Jungerman Circle • Suite 103 • St. Peters, Missouri 63376
Tel: 314-469-1230 Fax: 314-469-6709

Glaucoma Consultants of St. Louis, LLC

Last Name_____ First Name _____ Middle Initial_____

Date of Birth ____/____/_____ Sex: M/F/Other Marital Status _____ SS#_____

Address _____

City _____ State _____ Zip _____ Email _____

Communication Preference: Home Phone / Cell Phone / Email / None

Home Phone _____ Cell Phone _____ Other _____

Emergency Contacts

Name _____ Relation _____ Phone _____

Name _____ Relation _____ Phone _____

Insurance Information

Primary Insurance _____ Member ID _____

Secondary Insurance _____ Member ID _____

Does this insurance require referrals from your primary physician to see a specialist? Y / N
If yes, you are responsible for calling your primary care physician to obtain a referral 1 week prior to your visit.
Example insurances: Essence, Aetna HMO (previously Coventry HMO)

Authorizations:

I hereby authorize the release of information necessary for my insurance company to process my claim. The above information is correct to the best of my knowledge. I hereby authorize payment directly to Glaucoma Consultants of St. Louis, LLC insurance benefits otherwise payable to me. I understand I am financially responsible for charges not paid in a timely manner by my insurance. I consent to be called on any telephone number given to the provider, including cell phone numbers and email addresses. I understand that the provider's facility and/or collection agency will be calling the above contact numbers using an automatic telephone system.

Sign _____ Date _____

Glaucoma Consultants of St. Louis, LLC
Medical History and Review of Systems

Patient Name _____ Date of Birth____/____/_____

Primary Care Physician_____ Other Doctors_____

Primary Eye Doctor or Referring Doctor _____

Pharmacy Local_____ Phone_____
Mail Order _____

Previous Eye Surgeries_____

Current Eye Medications _____
Previous Eye Medications _____

Current or Past Medical Problems (check if yes)

___ Diabetes
___ Rheumatoid Arthritis (RA)
___ Atrial Fibrillation (Afib)
___ Cancer _____
___ High Blood Pressure
___ High Cholesterol
___ Heart Attack
___ Congestive Heart Failure (CHF)
___ Pacemaker
___ Mitral Valve Prolapse (MVP)
___ Stroke _____
___ TIA _____
___ Other:_____

___ Headaches/Migraines
___ Asthma
___ Emphysema
___ Sleep Apnea
___ Thyroid Disease
___ Anxiety
___ Depression
___ Lupus
___ Herpes
___ Hepatitis A/B/C
___ Alcohol/Drug Abuse
___ HIV/AIDS

Prior Surgeries Unrelated to eyes:

___ Hip Replacement
___ Knee Replacement
___ Heart Stent
___ Heart Bypass
___ Dialysis
___ Other: _____

___ Hysterectomy
___ Appendectomy
___ Mastectomy
___ Herniorrhaphy
___ Gallbladder

Have you ever used or currently used these medications?

___ Flomax
___ Long term oral steroids
___ Plaquinil

___ Amiodarone
___ Tamoxifen
___ Metformin

Drug Allergies _____
Are you allergic to: ___Latex ___Adhesive Tape ___ Betadine ___

Family Eye History ___Glaucoma_____ ___Macular Degeneration_____

Do you: Smoke? Y/N How often?_____ ___Drink Y/N How often?_____ Drive? Y/N

***Please provide a copy of your current medication list. If you do not have a copy, please use the back of this sheet to write down you list of medications.

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HIPAA Notice of Privacy Practices

We are required by Federal Law to provide each patient with the foregoing document, known as "Notice of Privacy Practices". Your signature does **NOT** signify agreement with any of the contained provisions, **ONLY THAT YOU HAVE RECEIVED THE NOTICE**.

We must maintain this signature on file for a period of six years. These regulations are a result of an act of Congress known as HIPAA, passed in 1996 and finally revised to its final form. It officially took effect on April 14, 2003. Because there are so many pages for the regulations, we do not mail these documents out. If you would like to read the notice ahead of time you may visit: www.hhs.gov.hipaa.

PRINT NAME:_____

SIGNATURE: _____

DATE:_____

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Chesterfield, MO 63017
Ph: 314-469-1230 Fax: 314-469-6709

APPOINTMENT CARD

Date: _____

Time: _____

Day of Week _____ __

_____

If you have a HMO– referral based insurance, it is the patients responsibility to call and request a insurance referral from their primary care physician.

Fill out our new patient form, bring your ID, insurance cards and all eye drops you are currently taking.