

PATIENT INFORMATION

NAME _____ E-MAIL ADDRESS _____
LAST FIRST MIDDLE

MAILING ADDRESS _____
STREET APT/LOT/ROOM CITY STATE ZIP CODE

TELEPHONE NUMBERS: (PLEASE INCLUDE AREA CODES)

HOME _____ WORK _____ CELL/PAGER _____

At which number would you prefer to be reached at between 9a-5p? **Circle:** HOME - WORK - CELL/PAGER; **Best Time to Call (between 9a-5p)** _____ a.m. _____ p.m.

PATIENT BIRTH DATE _____ MALE FEMALE SOCIAL SECURITY NUMBER _____
MONTH/DAY/YEAR

SPOUSE'S NAME _____ SPOUSE'S BIRTH DATE _____
LAST FIRST MIDDLE MONTH/DAY/YEAR

EMERGENCY CONTACT (OTHER THAN SPOUSE) _____ DAYTIME PHONE# _____
LAST FIRST (INCLUDE AREA CODE)

PRIMARY CARE PHYSICIAN? _____ OFFICE PHONE# _____
(INCLUDE AREA CODE)

PATIENT'S EMPLOYER _____ POSITION HELD _____

BILLING INFORMATION

PERSON RESPONSIBLE FOR PATIENT ACCOUNT (EXCLUDES WORKERS COMPENSATION)

SAME AS PATIENT PARENT POWER OF ATTORNEY (POA)* GUARDIAN* OTHER _____

NAME _____ PHONE # _____
LAST FIRST (INCLUDE AREA CODE)

ADDRESS _____
STREET APT/LOT/ROOM CITY STATE ZIP CODE

RELATIONSHIP TO PATIENT: _____

* POA / GUARDIAN: WE WILL NEED TO MAKE PHOTOCOPIES OF THESE LEGAL PAPERS -- PLEASE BRING TO PATIENT APPOINTMENT

REFERRAL INFORMATION

HOW DID YOU HEAR ABOUT BRUMM EYE & LASER VISION? PLEASE TELL US

FAMILY / FRIEND / CO-WORKER. WHO? _____

PHYSICIAN. WHO? _____

CIRCLE ALL THAT APPLY: PHONEBOOK / NEWSPAPER / INTERNET / RADIO / OTHER _____

INSURANCE INFORMATION



(PLEASE BRING YOUR INSURANCE CARD(S)/PHOTOCOPIES WILL NEED TO BE MADE)

ARE YOU COVERED BY ANY OF THESE INSURANCE COMPANIES?

MEDICARE YES NO MEDICARE # _____

MEDICARE COMPLETE (UHC) YES NO MEMBER # _____ GROUP # _____

NEBRASKA MEDICAID YES NO MEMBER # _____

TITLE XIX (19) IOWA MEDICAID YES NO MEMBER # _____

OTHER YES NO (COMPLETE INFORMATION BELOW)

1. NAME OF INSURANCE COMPANY _____

MEMBER # _____ GROUP # _____

POLICY HOLDER / INSURED'S INFORMATION:

NAME _____ RELATIONSHIP TO PATIENT _____

BIRTH DATE _____ SOCIAL SECURITY NUMBER _____
MONTH / DAY / YEAR

EMPLOYER'S NAME _____

EMPLOYER'S ADDRESS _____

2. NAME OF INSURANCE COMPANY _____

MEMBER # _____ GROUP # _____

POLICY HOLDER / INSURED'S INFORMATION:

NAME _____ RELATIONSHIP TO PATIENT _____

BIRTH DATE _____ SOCIAL SECURITY NUMBER _____
MONTH / DAY / YEAR

EMPLOYER'S NAME _____

EMPLOYER'S ADDRESS _____

FINANCIAL RESPONSIBILITY

I understand that I am responsible for the cost of my eye care if I: Seek eye care outside the parameters defined by my primary and/or secondary insurance carrier(s); Fail to get the required referrals and/or authorizations for my eye care; Fail to supply accurate and complete insurance / billing information at the time of my appointments.

I understand I am responsible for my bill and any insurance co-pays, co-insurance, and/or deductibles. I understand I am responsible for any charges not covered by my insurance carrier(s).

I hereby authorize release to my insurance carrier(s) any information acquired in the course of my examination and treatment. I hereby authorize direct payment of any medical and/or surgical benefits otherwise due to the Brumm Eye Laser Center for professional services rendered.

I authorize the use of this form on any insurance submission(s). A photostatic copy hereof shall be valid as an original.

Name (printed) _____

Signature _____

Date _____

PATIENT NAME: _____

MEDICAL HISTORY

PLEASE LIST
◆ CURRENT MEDICATIONS:

PLEASE LIST
◆ MEDICATION ALLERGIES? OR NONE

◆ HAVE YOU OR A FAMILY MEMBER EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING MEDICAL CONDITION (S):

	<u>SELF</u>		<u>FAMILY</u> : PARENTS, SIBLINGS, ETC.
	(CIRCLE)	WHEN?	(CIRCLE)
	NO		NO
	YES		YES
1. CATARACTS	NO	_____	NO
	YES	_____	YES
2. GLAUCOMA	NO	_____	NO
	YES	_____	YES
3. MACULAR DEGENERATION	NO	_____	NO
	YES	_____	YES
4. EAR, NOSE, THROAT, MOUTH PROBLEMS ..	NO	_____	NO
	YES	_____	YES
5. HIGH BLOOD PRESSURE	NO	_____	NO
	YES	_____	YES
6. HEART PROBLEMS	NO	_____	NO
	YES	_____	YES
7. RESPIRATORY (COPD, ASTHMA, ETC)	NO	_____	NO
	YES	_____	YES
8. STOMACH, DIGESTIVE	NO	_____	NO
	YES	_____	YES
9. ARTHRITIS, LUPUS	NO	_____	NO
	YES	_____	YES
10. DIABETES	NO	_____	NO
	YES	_____	YES
11. THYROID	NO	_____	NO
	YES	_____	YES
12. BLOOD DISORDER / DISEASE	NO	_____	NO
	YES	_____	YES
13. HEPATITIS / HIV	NO	_____	NO
	YES	_____	YES
14. NEUROLOGICAL (STROKE)	NO	_____	NO
	YES	_____	YES
15. PSYCHIATRIC	NO	_____	NO
	YES	_____	YES
16. URINARY (KIDNEY, BLADDER) ..	NO	_____	NO
	YES	_____	YES
17. CANCER / OTHER	NO	_____	NO
	YES	_____	YES

◆ SURGICAL HISTORY: including eye surgery (include dates) _____

◆ SOCIAL HISTORY:
 Do you smoke or use tobacco? YES or NO If yes, how much per day? _____
 Do you drink alcohol? YES or NO If yes, how often? _____
 If female, could you be pregnant now? YES or NO
 ◆ DATE OF LAST EYE EXAM (if not here) _____ BY WHOM? _____

OFFICE USE ONLY

PATIENT SIGNATURE: _____ DATE: _____