New Patients

Thank you for choosing Brumm Eye & Laser Vision. We look forward to serving your eye care needs!

COPAYMENTS ARE DUE AT TIME OF VISIT

- Arrive 15 minutes before your appointment time. If you're unable to make your appointment time please contact us.
- If you are more than 15 minutes late to your appointment we reserve the right to reschedule.
- Bring **ALL** prescription eyewear and contact lens information
- You **MUST** present all your insurance card(s), updated Medicine list, completed paperwork, & photo ID at check-in before services are provided.
- You are responsible for cost of all services and materials if you do **NOT** present your **CURRENT** Insurance information at the time of service.
- You are responsible for knowing the requirements and providers of your Medical Insurance and Medicare Plan coverage.
- Some insurance plans require a written referral/ authorization from your Primary Care Physician before services are provided.
- If patient is under the age of 19 they **MUST** be accompanied by a parent or guardian to be seen.
- Plan on being dilated, and bring a driver if you feel you may be uncomfortable driving afterwards.

Please make all checks payable to: *Brumm Eye & Laser Vision*

NOTICE OF PRIVACY PRACTICES GIVEN: ____________________

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.

PATIIENT 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 ______________________

Brumm Eye & Laser Vision

Patient name: ____________________

► MEDICAL HISTORY

Do you currently have or have you ever had any problems in the following areas?

Condition	Patient History Yes	No	Details	Family History Yes	No	Details
GENERAL CONSTITUTIONAL (fever, weight loss / gain, etc.)						
CATARACTS						
GLAUCOMA						
MACULAR DEGENERATION						
EYES (loss of vision, double vision, retinal detach, etc.)						
EARS, NOSE, THROAT, MOUTH (earache, stuffy nose, cough, dry mouth, etc.)						
RESPIRATORY / ASTHMA (COPD, wheezing, congestion, etc.)						
CARDIOVASCULAR (heart attack, high blood pressure, etc.)						
GASTROINTESTINAL (stomach ulcers, intestinal disease, etc.)						
KIDNEY, BLADDER, GENITAL (frequent urination, etc.)						
MUSCLES, BONES, JOINTS / ARTHRITIS (pain, stiffness, swelling, cramps, etc.)						
SKIN (cold sores, rash, Rosacea, etc.)						
NEUROLOGICAL / STROKE (numbness, headache, etc.)						
ENDOCRINE / DIABETES (thyroid condition, etc.)						
BLOOD / LYMPH (anemia, etc.)						
HEPATITIS / HIV						
ALLERGIC / IMMUNOLOGIC (sneezing, swelling, itching, hives, redness, etc.)						
PSYCHIATRIC (anxiety, depression, insomnia, etc.)						
CANCER						
OTHER						
Do you have a pacemaker or defibrillator? □ NO □ YES						
Have you ever had an adverse reaction to anesthesia? □ NO □ YES If yes, explain:						

► SURGICAL HISTORY: including eye surgery & dates ____________________

____

____

► SOCIAL HISTORY:

Do you smoke or use tobacco? NO or YES If yes, how much per day? ____________________

Do you drink alcohol? NO or YES If yes, how much / often? ____________________

Female patients: Could you be pregnant now? NO or YES

Your last eye examination (if not here) Date: ____________ By whom? ____________________

____________________ ____________________

Patient signature Date

Office Use Only											
Initials											
Date											
Initials											
Date											
Initials											
Date											

Patient name: ______________________________

Brumm Eye & Laser Vision

Office Use Only

Please List ► **CURRENT MEDICATIONS**:

Have you ever taken FLOMAX? ☐ **YES** ☐ **NO**

Please List ► **MEDICATION ALLERGIES / DRUG ALLERGIES** ☐ **No Known Allergies**

______________________________ ______________

Patient signature Date

Dated: 1/27/2010; cmt; updated: 2/01/2010--cmt