BROOKS EYE
ASSOCIATES

NEW PATIENT INTAKE FORMS

PLEASE COMPLETE ALL FIELDS

PATIENT INFORMATION: Today's Date: _____

Last Name: _____ Legal First Name: _____ MI _____
Race _____ Date of Birth: _____ Age: _____ Gender: M or F (circle one)
Marital Status: _____ SS#: _____ Employer: _____
Address: _____ Apt: _____
City: _____ State: _____ Zip Code: _____
Preferred Phone #: _____ Alternate Phone #: _____
Email Address: _____

Who referred you to our practice? _____
Who is your **Optometrist**? _____ Phone: _____
Who is your **Primary Care Physician**? _____ Phone: _____
Preferred Pharmacy: _____ Phone: _____
Pharmacy Address or Cross Streets: _____

Emergency Contact:
Name: _____ Relationship: _____
Phone #: _____

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I acknowledge that I have received, or have had the opportunity to review, a copy of the Brooks Eye Associates Privacy Practices packet. I understand that this is for informational and educational purposes only and it is a requirement of HIPAA guidelines that my physician practice provides this notice to me upon my request.

Signature _____ Date _____

NOTICE REGARDING EYE REFRACTION

A refraction is a diagnostic test that can help determine your eyeglass prescription. A **diagnostic** refraction is required by your insurance company as documentation to evaluate for possible cataract surgery. However, an **eyeglass** refraction is not covered by most medical insurances. If you request an eyeglass refraction, we will provide a copy of your eyeglass prescription to you for a fee of $75. If the patient chooses to request an eyeglass prescription, the fee of $75 will be collected in addition to any co-pays or deductible amounts at the time of service.

In signing this form, please understand you are only acknowledging our policy regarding eyeglass refractions. You will **not be charged any fees unless you request an eyeglass prescription from our office.

Signature _____ Date _____

BROOKS EYE ASSOCIATES

PATIENT CONSENT FORMS

Patient Name: _____ DOB: _____

FINANCIAL/INSURANCE POLICY

- All payment for services rendered are due at the time of service, unless prior arrangements have been made.
- Our staff will do our best to verify your benefits accurately prior to services being rendered. We will also file your insurance plan as a courtesy to you. However, the quotes we are provided by the insurance are never a guarantee of payment, and any outstanding balance or services not paid by your insurance plan are the patient's responsibility.
- We must have a copy of your insurance card and a valid photo ID in order to file claims to your insurance for services rendered. If this information is not provided to us, you may be required to be a self-pay patient.
- Any refund owed to the patient after all claims process will be refunded to the original payment method used. Cash payment refunds will be refunded in the form of a check.
- If you have had services rendered at both Brooks Eye Associates and Surgery Center 121, LLC and there is a balance and/or credit on either account after all claims process, an internal transfer between entities will take place to reconcile both accounts prior to either collecting a balance from the patient or refunding the patient.
- Any products purchased from Brooks Eye Associates, whether used or unused, are unable to be returned for credit or refund for any reason.
- There will be a $35 fee for all returned checks.
- Medical forms (FMLA, Disability, Medical Records) are available for a fee of $25 for standard processing (5-7 business days). Expedited release (1-2 business days) is also available for a fee of $75.

I authorize Brooks Eye Associates to furnish my insurance company, or its representatives, with the customary medical information required to process medical claims. I understand that Brooks Eye Associates will file my insurance on my behalf and I will be responsible for following up with my insurance company for timely payment of services rendered. I agree to pay in full all balances due that are not paid by the insurance company.

Signature _____ Date _____

CONSENT FOR USE AND DISCLOSURE OF INFORMATION

I consent to the use or disclosure of my protected heath information for the following purposes:

- TREATMENT: It will be necessary to share health information with all members of the treatment team for treatment purposes. This may include employees of this office, as well as other providers.
- PAYMENT: Necessary information will be shared with your insurance plans and their representatives for reasons including, but not limited to, eligibility, benefit determination, and claim management. Information will also be shared, as appropriate, with billing personnel, including but not limited to employees, case managers, claims representatives, third party billing services or clearinghouses in order to carry out job functions.
- HEALTHCARE OPERATIONS: Necessary information will be shared for the continuing operations of this office including but not limited to peer review, accreditation, credentialing, and compliance with state and federal laws.
- I understand that my treatment may be conditioned upon my consent. This consent is given freely and I understand that I can revoke this consent at any time in writing, which will apply to disclosures and uses made subsequent to the revocation date.

DISCLOSURE OF MEDICAL INFORMATION

Please list below the names of individuals with whom you authorize members of our office staff to discuss your medical information (ex: spouse, parent, etc). A person not listed on this list will not be able to access any of your information.

Name _____ Relationship _____

Name _____ Relationship _____

Signature _____ Date _____

BROOKS EYE
ASSOCIATES

MEDICAL HISTORY QUESTIONNAIRE

Patient Name: _____
What is the reason for your visit today? _____
_____

History of EYE SURGERY?			Right Eye	Left Eye
Cataract Surgery	Yes or No	Date(s):	_____	_____
Cornea Surgery	Yes or No	Date(s):	_____	_____
Glaucoma Surgery	Yes or No	Date(s):	_____	_____
LASIK/PRK Surgery	Yes or No	Date(s):	_____	_____
Strabismus Surgery	Yes or No	Date(s):	_____	_____

History of EYE DISEASES or conditions? Yes or No (circle one) (Ex: glaucoma, macular degeneration, iritis, etc.)

Yes or No (circle one) If yes, explain: _____
List of current eye drops being used: _____
Do you wear contact lenses? Yes or No If yes, are they SOFT or HARD lenses? _____
Family history of eye disease? Yes or No If yes, please explain: _____

FAMILY HISTORY OF:

High Blood Pressure	Yes or No	Relationship: _____
Heart Disease	Yes or No	Relationship: _____
High Cholesterol	Yes or No	Relationship: _____
Cancer	Yes or No	Relationship: _____
Diabetes	Yes or No	Relationship: _____
Stroke	Yes or No	Relationship: _____

Please list ALL previous surgeries:

Procedure	Approximate Year

SOCIAL HISTORY

Smoking: [ ] Current Everyday Smoker [ ] Current Some Day Smoker [ ] Former Smoker [ ] Never Smoked [ ] Smoker, Status Unknown [ ] Unknown if ever Smoked	**Alcohol Use:** [ ] Never [ ] Rarely [ ] Occasional [ ] Daily [ ] Frequently [ ] Heavy	**Hobbies:** [ ] Computers [ ] Music [ ] Sewing/Crafts [ ] Sports [ ] Travel [ ] Golf [ ] Hunting [ ] Reading [ ] Other _____	**Occupation:** [ ] Business [ ] Manual Labor [ ] Office Work [ ] Retired [ ] Student [ ] Teacher [ ] Driver/Pilot [ ] Engineer
Type of Tobacco: [ ] Cigarettes [ ] Cigar [ ] Pipe [ ] Electric/Vape	**Type of Alcohol:** [ ] Beer [ ] Liquor [ ] Wine	**Recreation Drugs:** [ ] Never [ ] Rarely [ ] Occasional [ ] Daily [ ] Frequently [ ] Heavy	**Type of Drug:** [ ] Amphetamines [ ] Cocaine [ ] IV Drugs [ ] LSD [ ] Marijuana

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ASSOCIATES

MEDICAL HISTORY QUESTIONNAIRE

Please list any drug allergies:

[___] NO KNOWN DRUG ALLERGIES

Allergy to:	Reaction:

List ALL medications you are currently taking including prescription, OTC, vitamins, topicals, and supplements:

Medication Name	Dosage and Frequency	Reason for Taking

LIFESTYLE VISION ASSESSMENT

1. What are some of your favorite hobbies? _____
2. If you are working, what is your occupation and some of your daily work-related tasks? _____

   _____
3. If Dr. Brooks determines that you are an appropriate candidate for the advanced technology currently available, would you be open to hearing about an implant that could significantly reduce or eliminate your need for glasses? Yes or No (circle one)
4. If you had to wear glasses/contacts after surgery, for which activity would you be the most willing to use them for? (Circle one) Reading Fine Print Computers TV/Driving
5. How would you describe your personality? (Circle one) Easy going In between Meticulous/Detailed

****It is important to understand that some people still need to wear glasses for certain activities after surgery.**