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#: _____

Address: _____Apt: _____
City: _____ State: _____Zip Code: _____

Preferred Phone: _____Alternate Phone: _____
Email Address: _____

How did you hear about us? (circle one)

Referring Provider/Optometrist Previous Patient Social Media Drive By

Facebook Hospital/Urgent Care Insurance Internet Our Website

Who is your **Optometrist**? Did they refer you to our practice? **Yes or No**

First Name: _____ Last Name: _____
City/Location: _____ Phone: _____

Who is your **Primary Care Physician**? Did they refer you to our practice? **Yes or No**

First Name: _____ Last Name: _____
City/Location: _____ Phone: _____

If referred by a doctor other than your Optometrist/Primary Care Physician, please list referring provider name here: _____

Preferred Pharmacy: _____Phone: _____
Address or Cross Streets: _____

Emergency Contact:
Name: _____Relationship: _____
Phone #: _____

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Today's Date: _____

Patient Name (please print): _____ 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 (3 business days).

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.

Patient Signature _____ Date _____

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.

Patient Signature _____ Date _____

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Today's Date: _____

Patient Name (please print): _____ DOB: _____

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 this consent can be revoked 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 _____

Patient Signature _____ Date _____

NOTICE REGARDING EYE REFRACTION

Brooks Eye Associates' office policy is to perform at least one refraction per year as a diagnostic part of a cataract evaluation or medical evaluation. A refraction is a diagnostic test used to determine the best possible function of the eye. It provides medical information necessary to properly evaluate eye health and look for eye disease.

Each insurance may cover the refraction differently, and it's possible it may not be covered at all. Medicare is a plan that does not cover the refraction, so for Medicare patients, we will collect the refraction fee of $49 on the date of service. For all other insurance plans, our insurance department will do their due diligence to verify your plan benefits, and we will collect for the refraction according to your specific plan's coverage. If the refraction is a non-covered service according to your plan, we will collect the $49 out-of-pocket rate for this service.

If the patient requests a refraction specifically to receive an eyeglass prescription, the patient must be seen by one of our optometrists on staff specifically for this service, in conjunction with an office visit. This service is only available to patients who do not already have a primary optometrist.

I have read the above information and understand that in many cases, a refraction is a non-covered service. I accept full financial responsibility for the cost of the refraction as dictated by my insurance plan, or up to the amount of $49 if my insurance plan does not cover it. I understand that any co-payments, co-insurance, or deductibles that I may owe for my visit and/or other testing performed, are separate from and not included in the refraction fee.

Patient Signature _____ Date _____

BROOKS EYE ASSOCIATES

Today's Date: _____

Patient Name (please print): _____ DOB: _____

MEDICAL HISTORY QUESTIONNAIRE

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: _____

Are you under hospice care? Yes or No

SOCIAL HISTORY:

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

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Today's Date: _____

Patient Name (please print): _____ DOB: _____

Please list ALL previous surgeries:

Type of Procedure	Approximate Year

Please list ALL 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? (Circle one) Yes or No
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.**