PATIENT INFORMATION FORM

Name: ____
First Name Middle Initial Last Name

Local Address: ____

City: ______________________ State: ____________ ZIP Code: ______________

Home Phone #: ______________________ Work Phone #: ______________________

Cell Phone #: ______________________ Email: ______________________

Mailing or "Summer" Address: ____

City: ______________________ State: ____________ ZIP Code: ______________

Phone #: ______________________

SSN#: ______________________ Date of Birth: ______________________

Gender: Male Female

Marital Status: ______________________ Name of Spouse: ______________________

Patient's Occupation: ______________________ Employer: ______________________

Work Address: ______________________________________ City: ______________

State: __________ ZIP Code: ______________ Phone #: ______________________

In Case of an Emergency, we may contact:

Name: ______________________________________ Phone #: ______________________

Address: ____

City: ______________________ State: ____________ ZIP Code: ______________

Referred to our office by: ____

Insurance Carrier (If applicable): ____

*****Please present all insurance cards to the front desk*****

Please check with the front desk to make sure we participate in your insurance plan. Failure to do so may result in a denial from your carrier or payment out-of-pocket.

I hereby authorize Robert N. Brems, M.D. Dana D. Bates, O.D. and Cody D. Quarnberg,O.D. to furnish information to insurance carriers concerning my illness and treatment, and I hereby assign to the physician all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance. I further permit a copy of this authorization to be used in place of the original. I also give permission to submit charges and diagnosis to my secondary insurance carrier if applicable.

DATE: ______________ SIGNATURE: ______________________________________

Patient Medical History

Robert N. Brems, M.D. Dana D. Bates, O.D. Cody D. Quarnberg, O.D.

Patient name:____

Reason for visit: Routine Exam Eye Problem LASIK Consult

Do you presently wear glasses? (YES) (NO)

If yes, are they for: Distance Reading Bifocals Trifocals No-line/Progressive

Do you presently wear contact lenses? (YES) (NO)

If yes, the brand name is: ______________________B.C.______DIA________

RX (power): Right Eye______________ Left Eye ______________

Are you allergic to any medications? (YES) (NO)

If yes, please list:____

____

Do you take any daily medications? (YES) (NO)

If yes, please list:____

____

____

____

____

Have you ever smoked? (YES) (NO)

If yes, do you currently smoke? (YES) (NO)

Have you ever had:

Arthritis	(YES)	(NO)	Hepatitis	(YES)	(NO)
Cancer	(YES)	(NO)	Kidney Disease	(YES)	(NO)
Diabetes	(YES)	(NO)	Stroke	(YES)	(NO)
Thyroid Disease	(YES)	(NO)	High Blood Pressure	(YES)	(NO)
Heart Disease	(YES)	(NO)	Mini-Stroke (TIA)	(YES)	(NO)
Heart Attack	(YES)	(NO)	Lung Disease	(YES)	(NO)
Liver Disease	(YES)	(NO)	O2 (Oxygen) use	(YES)	(NO)
Neurological Disorder	(YES)	(NO)	Cataracts	(YES)	(NO)
Glaucoma	(YES)	(NO)	Macular Degeneration	(YES)	(NO)
Eye Muscle Problems	(YES)	(NO)	Lazy Eye/Amblyopia	(YES)	(NO)

Do any members of your immediate family have:

Diabetes	(YES)	(NO)	Glaucoma	(YES)	(NO)
Cataracts	(YES)	(NO)	Macular Degeneration	(YES)	(NO)

List any previous surgeries or hospitalizations:______________________________

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____

____

--THIS SIDE FOR DOCTOR'S OFFICE USE ONLY—

Any changes in general health since last annual exam:____

Any changes in Medications since last annual exam:

Robert N. Brems, M.D.
Dana D. Bates, O.D.
Cody D. Quarnberg, O.D.

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Phoenix, AZ 85012
(602) 200-0770

9746 N. 90th Street, Suite 101
Scottsdale, Arizona 85258
(480) 391-0020

General Insurance Waiver

Some insurance companies will only pay for services which they deem reasonable and medically necessary. If your insurance company determines that a particular service, although it would be otherwise covered, is not reasonable or medically necessary, it will deny payment for that service. Examples of some of the services that may be denied are ***refractions or contact lens fittings***, a balance left that went toward your ***deductible***, or any procedure done for ***routine*** or ***cosmetic*** reasons. There is a possibility that other procedures may be denied. Reasons for denial maybe "non-allowed" or "non-covered" services. ***Routine eye exams that show no medical problems may not be covered by medical insurance.***

Name:____

Signature:__________________________________Date:_______