Jeffrey K. Brummer, D.O.
P.O. Box 665 • Effingham, IL 62401

Date of Application ____________________

Have you applied here before? ☐ Yes ☐ No

Previously seen by: ☐Dr. M. Brummer ☐Dr. J. Brummer ☐Dr. Bingham ☐Dr. Heischmidt ☐Dr. Crowell ☐Dr. Bierman

Who is Applying? (check all that apply): ☐ Self (Guarantor) ☐ Spouse/Partner ☐ Children

○ **Guarantor's Full Name:** ________________________________ Gender: ________ DOB: ____________
(Responsible Party) LAST FIRST MIDDLE
Transgender ☐

Previous/Maiden Name: ____________________ ☐Married ☐Single ☐Divorced ☐Separated ☐Widowed

Address: ________________________________ City: ____________ St.: ________ Zip: ________

Home Ph: ________________ Cell Ph: ________________ Email: ________________________

Social Security No.: ________________________ Driver's License No.: ________________________

Race: ☐White ☐Asian ☐Native Hawaiian ☐African American ☐Hispanic

☐American Indian or Alaskan Native ☐Other Pacific Islander Other Race

Ethnicity: ☐Hispanic ☐Non Hispanic Translator Needed? ☐Yes ☐No

Employer: ________________________________ Phone No.: ________________ Ext.: ________

Address: ________________________________ City: ____________ St.: ________ Zip: ________

Occupation: ________________________________

○ **Spouse/Partner Full Name:** ________________________________ Gender: ________ DOB: ____________
LAST FIRST MIDDLE
Transgender ☐

Previous/Maiden Name: ____________________ ☐Married ☐Single ☐Divorced ☐Separated ☐Widowed

Address: ________________________________ City: ____________ St.: ________ Zip: ________

Home Ph: ________________ Cell Ph: ________________ Email: ________________________

Social Security No.: ________________________ Driver's License No.: ________________________

Race: ☐White ☐Asian ☐Native Hawaiian ☐African American ☐Hispanic

☐American Indian or Alaskan Native ☐Other Pacific Islander ☐Other Race

Ethnicity: ☐Hispanic ☐Non Hispanic Translator Needed? ☐Yes ☐No

Employer: ________________________________ Phone No.: ________________ Ext.: ________

Address: ________________________________ City: ____________ St.: ________ Zip: ________

Occupation: ________________________________

○ **Children:** ____________________ DOB: ________ S.S. No.: ____________ Sex: ___ Transgender ☐ Race: ________
FULL NAME **or expected due date**

____________________ DOB: ________ S.S. No.: ____________ Sex: ___ Transgender ☐ Race: ________

____________________ DOB: ________ S.S. No.: ____________ Sex: ___ Transgender ☐ Race: ________

____________________ DOB: ________ S.S. No.: ____________ Sex: ___ Transgender ☐ Race: ________

PLEASE CONTINUE ON BACK:

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In case of emergency, contact (Other than spouse): ____________________

Address: ____________________ City: ____________ St.: ________ Zip: ________

Relationship: ____________________ Phone No.: ____________ Ext: ________

Current Physician ____________________

Primary Insurance Coverage	**Secondary Insurance Coverage**
Carrier Name & Address: ____________________	Carrier Name & Address: ____________________
Group No.: ____________________	Group No.: ____________________
Identification No.: ____________________	Identification No.: ____________________
Subscriber Name: ____________________	Subscriber Name: ____________________
Subscriber's Birthdate: ____________________	Subscriber's Birthdate: ____________________
Subscriber's SS#: ____________________	Subscriber's SS#: ____________________
Effective Date: ____________________	Effective Date ____________________

Are you covered by Medicaid? ☐ Yes ☐ No ID# ____________________

Are you covered by Medicare? ☐ Yes ☐ No ID# ____________________

○ **Please provide a front and back copy of all insurance cards, including Medicare and/or Medicaid.**

○ **Please provide a copy of your current driver's license or other photo ID.**

We require payment, and/or co-payment, the day of service for all office visits.

We ask all patients to show their insurance membership card so that we may copy them. Medicaid Card must be presented at each visit or payment is due the day of service. We cannot render services on the assumption that our charges will be paid by an insurance company. All services are charged directly to the patient, and he or she remains personally responsible for payment. As a courtesy, however, we will prepare any necessary reports and itemizations to assist in making collections for insurance companies and will credit such collection to the patient's account.
I give my consent to **Family Care Associates of Effingham, S.C.** to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in the patient record of my family members. I have been informed and understand that I am personally responsible for the full payment of my account. In the event my account is past due more than 60 days, a finance charge will be assessed. If I have not made arrangements for payments after 90 days, I will be responsible for all fees incurred for collection and/or attorney fees.

Family Care Associates is a medical home dedicated to the comprehensive healthcare of the patients we serve. We are not a walk-in clinic. When you complete and sign your application, you agree to medical care fully managed by your new physician at Family Care Associates. Upon acceptance, previous medical records may be transferred to Family Care Associates. Complete our "Authorization for Release of Confidential Health Information" form directing records to Family Care Associates, or contact your former physician's office and request your records transferred. Thank you!

○ Signature: ____________________ Date: ____________

How did you hear about us? ☐ Radio ☐ Newspaper ☐ Friend ☐ Health Fair ☐ Website ☐ Other

Referred By: ____________________

Family Care Associates

Application for Medical Care

Please bring all of your current medications (in their BOTTLES) with you to your first appointment. If you are unsure of your medical history, please contact your previous physician and request a records transfer to Family Care Associates. If you need additional space, please use the back of this sheet. Thank you!

Name of Applicant ______________________________________

Date of your last **Mammogram**? ___________________________

Date of your last **Colorectal Screening**? ____________________
(Includes Hemoccult, Colonoscopy, Flex Sigmoidoscopy)

Please list your **current medications** (including over-the-counter):

____
____
____
____
____
____

Please list any additional medications you have taken in the last **12 months** (including over-the-counter):

____
____
____
____
____
____

Medication Allergies:

____
____
____

Side Effect/Reaction:

____
____
____

Pharmacy Name and Phone (so that we may call with questions) ____________________________________

Please list your past and current **health problems**:

Current:

____
____
____
____
____
____

Past:

____
____
____
____
____
____

Please list any **hospitalizations, operations, or injuries** (please ***include dates***):

Condition(s): **Date:**

____
____
____
____
____

Does this require ongoing medical treatment? If so, what? When was your last treatment?:

____
____
____
____
____

Which **doctors** have treated you in the past:

1. ____
2. ____
3. ____
4. ____

I hereby state all information given on this application/healthcare questionnaire to be true and correct. Once accepted as a patient, any information found to be untrue or incorrect could result in the dismissal of all individuals listed on this application.

_____________________________________ _________________________________
Applicant Signature **Date**

Thank you for choosing Family Care Associates!