PATIENT INFORMATION

Patient Name _____

Address _____
Street City State Zip

Home Phone # (_____)_____ **Date of Birth** _____/_____/_____ **Age** _____

Cell Phone # (_____) _____ **E-mail:** _____

Employer _____

Employer Address _____
Street City State Zip

Work Phone # (_____) _____ **Occupation** _____

Social Security # _____ **Driver's License #** _____

Spouse: _____ **Spouse Phone #:** _____

Emergency Contact: _____ **Phone #:** _____

NOTICE TO CONSUMERS: Medical doctors are licensed and regulated by the Medical Board of California question about licensure can be directed to: 800-633-2322 www.mbc.ca.gov

Dr. Brian Boxer Wachler's medical license number is G84557

I've read and understood the above statement about licensure and regulation of medical doctors.

Signature: _____ Date _____

* * * * * * * * * * * * * * *

FOR MEDICARE PATIENT'S ONLY – PLEASE READ AND SIGN

I authorize my Medicare and Secondary insurance benefits for medical services furnished by Boxer Wachler Vision Institute to be paid directly to Brian S. Boxer Wachler, MD. I understand I am financially responsible for any balance due after the insurance has made payment.

I understand if I've elected to change my Medicare benefits into a HMO plan, that I will be responsible for all service fees. Ophthalmology services by Dr. Brian Boxer Wachler are not covered under HMO benefits.

I further understand that services rendered with a diagnosis of nearsightedness, astigmatism, farsightedness, presbyopia or keratoconus are usually are not covered under my benefits. I understand services, procedures, or surgeries that are for the purpose of correcting vision or assessing my prescription (i.e. LASIK eye surgery, INTACS, C3-R, CK or measurement for glasses prescription) are uncovered benefits and I will be responsible for these fees.

I also authorize Brian S. Boxer Wachler, MD or the insurance company to release any information required for claims. I understand non-covered service fees are due at the time services are rendered unless other arrangements are made in advance.

Signature: _____ Date _____

Please give your insurance card to the front desk to make a copy of your card.

Medicare ID #: _____ Social Security #: _____

Secondary Insurance Name : _____ Secondary Insurance ID #: _____

Rev: 1/2/09

Ocular/Medical/General Information

Name _____ Date _____
(Last) (First) (Middle)

Date of Birth _____ Age _____ Occupation _____ Gender_____

Glasses History

1. How often do you wear eyeglasses or contact lenses for distance vision? ☐ Not at All ☐ Part-time ☐ Full-time
2. Do you need eyeglasses for reading? ☐ Yes ☐ No

Contact Lens History

3. Do you currently wear contact lenses? ☐ Yes ☐ No (if no, skip to 6)
4. What kind of contact lenses do you wear now? ☐ soft ☐ rigid gas permeable ☐ hard
5. How long have your contacts been out? _____
6. Reasons why not wearing contacts? _____

Ocular History

7. List all eye surgeries you have had. Indicate which eye and the date of surgery: _____
8. List eye injuries with dates: _____
9. List any eye diseases you have: _____
10. List all eye drops you use, which eye, and how often you use them: _____

General Medical History

11. List all other surgeries you have had, with dates:

_____

_____

12. Do you now or did you in the past have any of the following conditions?

			Please Specify
☐ Yes	☐ No	A topic disease	_____
☐ Yes	☐ No	Rheumatoid arthritis	_____
☐ Yes	☐ No	Autoimmune Disease	_____
☐ Yes	☐ No	Diabetes	_____
☐ Yes	☐ No	Hepatitis	_____
☐ Yes	☐ No	HIV infection	_____
☐ Yes	☐ No	Keloid formation	_____
☐ Yes	☐ No	other medical problems	_____
			_____

13. Do you smoke? ☐ Yes ☐ No

14. List all other medications and supplements you take with dosage and frequency: _____

_____

_____

15. List any medications you are allergic to: _____

_____

16. If female, are you or might you be pregnant? ☐ Yes ☐ No

17. If female, are you trying to become pregnant? ☐ Yes ☐ No

Family Medical History

18. List any eye diseases that run in your family: _____

_____

General History

19. What activities or hobbies do you participate in frequently? _____

_____

20. What activities do you avoid due to your eyes? _____

21. Have you visited our website? ☐ Yes ☐ No

22. What led you to make an appointment with us? (Check one)

☐ Dr. Boxer Wachler (or patient of his) ☐ Patient ☐ Website

☐ other (please tell us) _____

23. If you were referred to us, who referred you?

Doctor_____ Friend/Family_____

Other _____ Is this person a patient of ours? ☐ Yes ☐ No

Address_____

Street City State Zip Code

Phone # (_____)_____

24. PRIMARY EYE DOCTOR_____

◯ OPTOMETRIST/OPHTHALMOLOGIST ◯ (circle one)

Address and Phone # _____

25. MEDICAL DOCTOR _____

Address _____

Phone # _____

26. Any additional doctors or specialists providing you with medical care:

Name_____ Phone_____

Name_____ Phone_____

27. May we send a letter to your local doctors to update them on your visit(s) with us? (circle one) ◯ YES ◯ NO