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_____

What frustrations do you currently have that relate to your eyes?

List three or four of the reasons why you are now considering IBRITE Eye Whitening?

What frustrations do you have now because of your eyes?

List medical symptoms that have been difficult to diagnose:

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