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

Quality of Vision Questionnaire

Date: _____Patients Name: _____Date of Birth: _____

Place an X on the scale toward the direction that best rates your response to the questions below

How would your rate the quality of vision in glasses? …..…….
Poor Excellent

How would you rate the quality of your vision throughout the day in contacts? ……...……
Poor Excellent

How often are you able to obtain good vision in glasses? ……..…..
Never All the time

How well to you tolerate contacts? ……
Not at all Very high tolerance

How often are you able to wear contacts 8-12 hours? ……
Never All the time

Do you experience fluctuations in your vision throughout the day? ……...……
No fluctuations Severe fluctuation

Are you experiencing sensitivity to light? …….. ……
No sensitivity Severe fluctuation

When you encounter bright light, such as headlights Streetlights, etc, how much glare do you experience? ……...
No glare Significant glare

How often do you see halos around lights ? ……
Never All the time

How often does your vision affect your ability to work? ……
Never All the time

How often does your vision affect your ability to drive? ……
Never All the time

How often does your vision affect your day to day life? ……
Never All the time

How often does your vision affect your outlook on life? ……
Never All the time

Do you feel that the quality of care provided by your previous doctor has been unsatisfactory? ……
Not at all Highly

How else has your vision affected your life: ……

……

……