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 #: _____

Boxer Wachler Vision Institute
Patient Medical and Eye Information
for
Refractive Evaluation

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

Occupation _____ Employer _____

Date of Birth _____ Age _____ Gender _____

What frustrations do you currently have that relate to not being able to see as well as you like?

List three or four of the reasons why you are now considering a vision correction procedure?

Please share with us some of the physical activities that you hope to further participate in after your procedure?

What activities will you be able to more fully participate in after your vision is corrected?

What restrictions do you have now because of your use of contacts or glasses?

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. Are your contacts in today? _____ If not, how many days have they been out? _____

6. Have you tried monovision with contacts (one eye for distance vision, the other eye for reading)?
   ☐ Yes ☐ No

7. If you have tried monovision, was it successful for you? ☐ Yes ☐ No

Ocular History

8. List all eye surgeries you have had. Indicate which eye and the date of surgery: _____

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

10. List eye injuries with dates: _____

11. List any eye diseases you have: _____

General Medical History

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

			Please Specify
☐ Yes	☐ No	Atopic 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. List all eyedrops you use, which eye, and how often you use them: _____

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; might you be; or trying to become; pregnant? ☐ Yes ☐ No

17. If female, are you breastfeeding? ☐ Yes ☐ No

Family Medical History

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

_____

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

20. What led you to make an appointment with us? _____

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

Doctor_____

Friend/Family_____ Is this person a patient of ours? ☐ Yes ☐ No

Address_____

Street City State Zip Code

Phone # (_____)_____

22. EYE DOCTOR _____

Name OPTOMETRIST/OPHTHALMOLOGIST

Phone_____ (circle one)

Address _____

23. MEDICAL DOCTOR _____

Name

Phone_____

Address _____

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

Name_____ Phone_____