

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](http://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 \_\_\_\_\_

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**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?

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

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

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

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

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List medical symptoms that have been difficult to diagnose:

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### 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 \_\_\_\_\_