DR. BECHERER & ASSOCIATES, LTD

Dr. P. Douglas Becherer Dr. Jeffrey A. Kempf Dr. Joshua D. Wilson

WELCOME TO OUR OFFICE

Mr., Mrs., Ms., Miss, Dr., Other _____ Nickname_____Date_____

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

Address_____ City _____ State_____ Zip_____

Phone (home)_____ (work) _____Extension_____

Cell Phone _____ (may we call your cell phone? Yes / No)

E-mail _____

Birth Date_____ Age_____ Hobbies_____

Spouse_____ (Our Patient? Yes / No) Who recommended us? _____

If child: Parent or Guardian _____

Occupation _____ Employer_____

Social Security #_____ Medicare # _____

Will you be paying for today's services by: Cash, Check, Visa, MasterCard, Care Credit, Discover
Other_____

PLEASE NOTE: **We require payment when services are rendered. If you are using any kind of insurance, it is the policy owner's responsibility to know what your policy covers. A deposit is required on all materials with the balance paid in full upon delivery or shipping. Any bill which is 30 days overdue will be charged 1.5% per month service charge. In the event there is a default of payment, patient agrees to pay expenses of collection, including but not limited to attorney fees, court cost or collection company fees. If any kind of insurance is used and there are additional fees or charges owed, one billing statement will be sent at no charge. Each additional statement will be $6.00.**

Signature_____ **Date** _____

Personal Do you wear glasses? (Y/N) Contact Lenses? (Y/N) Type_____

Are you interested in contact lenses? (Y/N) Are you interested in refractive surgery? (Y/N)

Date of last eye exam_____ Doctors Name _____

Were your eyes dilated? Y/N If YES: any complications? _____

What was prescribed? _____Medicine _____Glasses _____Contact Lenses _____ Therapy

PLEASE TURN PAGE OVER AND FILL OUT MEDICAL HISTORY FORM

MEDICAL INFORMATION

Many conditions and medications affect your eyes and vision. Please list ALL medications and what they are for: _____

_____

_____

Review of systems: Please check if any apply (& add an "R" for a blood relative):

Allergic/Immunologic
____drug allergy
____environmental allergy
____rheumatoid arthritis
____lupus
____ other

List Drug Allergy
_____
_____
_____
_____
_____

Gastrointestinal
____Crohn's
____colitis
____ulcer
____digestive
____ other

Skin
____eczema
____rosacea
____psoriasis
____dry
____ other

Psychiatric
____ depression
____panic disorder
____schizophrenia
____ other

Heart
____heart disease
____ hypertension
____ stroke
____ vascular disease

Endocrine
____ diabetes (insulin)
____ diabetes (non-insulin)
____ thyroid problem
____ hormone changes

Genitourinary
____ STD
____ herpes
____ other

Respiratory
____asthma
____bronchitis
____emphysema
____ cigarettes (how much)

Neurologic
____ multiple sclerosis
____ epilepsy
____ other

Muscles/Skeletal
____ fibromyalgia
____ muscular dystrophy
____ osteoarthritis
____ ankylosing spodylitis
____ other

Blood/Lymphatic
____ anemia
____ leukemia
____ blood loss

Constitutional
____ developmental disability
____ weight loss
____ fever
____ fatigue
____ trauma
____ other

Eyes
____ cataract
____ glaucoma
____ macular degeneration
____ floaters/flashes
____ lazy eye
____ glare
____ color blindness
____ eye pain
____ dry eye
____ retinal problems
____ blurred vision
____ temporary vision loss

LIST ALL EYE SURGERIES & INJURIES, INCLUDING DATES: _____

_____

_____

_____ _____ _____