

DR. BECHERER & ASSOCIATES, LTD

Dr. P. Douglas Becherer Dr. Lisa A. Hager

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 spondylitis
- 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: _____
