



Bedminster Eye and Laser Center, P.A.

NOTICE TO ESTABLISHED PATIENTS

The Bedminster Eye staff understands how time consuming and unpleasant it is to complete the required paperwork when you arrive for your appointment.

Please print and fill out the forms listed below and bring them with you so that we can expedite your appointment. If you wish, you may also email the forms to info@bedminstereye.net.

If you are an **Established Patient** – and have been seen in our office within the last three years - you only need to complete the following forms annually*:

- ✓ Medical and Family History
- ✓ Review of Systems
- ✓ Medication List [**only if you do not have your own list**]

Unfortunately, patients who fill out their forms in the office may be significantly delayed with their visit.

*** Any changes to your demographic information and/or insurance coverage will require additional forms to be completed.**

My Medication List

Name _____

Date _____

	What I'm taking	Form (pill, injection, liquid, patch, etc.)	Dosage	How Much and When	Use (regularly or occasionally)	Start/Stop Dates (1/5/05 - 3/5/05) (1/5/05 - ongoing)	Notes, Directions, Reasons for Use
* Be sure to include ALL prescription drugs over-the-counter drugs, vitamins, and herbal supplements.							
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							

Name: _____ Date of Birth: _____ Today's Date: _____

Eyes	YES	NO
Previous Surgery	☐	☐
Contact Lens	☐	☐
Pain	☐	☐
Double Vision	☐	☐
Glaucoma	☐	☐
Cataracts	☐	☐
Macular Degeneration	☐	☐
Dry Eyes	☐	☐
Flashes	☐	☐
Floaters	☐	☐
Other	_____	

Ear, Nose, Throat	YES	NO
Hard of Hearing	☐	☐
Ringing in Ears	☐	☐
Vertigo	☐	☐
Sinus	☐	☐
Other	_____	

Cardiovascular	YES	NO
Chest Pain	☐	☐
Dizziness	☐	☐
Fainting Spells	☐	☐
Shortness of Breath	☐	☐
Irregular Heart Beat	☐	☐
Difficulty Lying Flat	☐	☐
Other	_____	

Constitutional	YES	NO
Fatigue/Weakness	☐	☐
Fever	☐	☐
Weight Gain/Loss	☐	☐
Other	_____	

Respiratory	YES	NO
Cough	☐	☐
Congestion	☐	☐
Wheezing	☐	☐
Asthma	☐	☐
Other	_____	

Gastrointestinal	YES	NO
Heartburn	☐	☐
Nausea/Vomiting	☐	☐
Jaundice/Hepatitis	☐	☐
Other	_____	

Genito-Urinary	YES	NO
Pain/Difficulty	☐	☐
Blood in Urine	☐	☐
History of Kidney Stones	☐	☐
History of STDs	☐	☐
Other	_____	

Psychiatric	YES	NO
Anxiety/Depression	☐	☐
Mood Swings	☐	☐
Difficulty Sleeping	☐	☐
Other	_____	

Endocrine	YES	NO
Increased Thirst	☐	☐
Increased Hunger	☐	☐
Increased Urination	☐	☐
Increased Sweating	☐	☐
Fingernail Changes	☐	☐
Other	_____	

Blood/Lymph Nodes	YES	NO
Easy Bruising	☐	☐
Gums Bleed Easily	☐	☐
Prolonged Bleeding	☐	☐
Heavy Aspirin Use	☐	☐
Other	_____	

Musculoskeletal	YES	NO
Stiffness	☐	☐
Arthritis	☐	☐
Joint Pain/Swelling	☐	☐
Other	_____	

Skin	YES	NO
Rash/Sores	☐	☐
Lesions	☐	☐
Hives/Eczema	☐	☐
Other	_____	

Neurological	YES	NO
Seizures	☐	☐
Weakness/Paralysis	☐	☐
Numbness	☐	☐
Tremors	☐	☐
Headaches	☐	☐
Migraines	☐	☐
Other	_____	

Immunologic	YES	NO
Hives	☐	☐
Itching	☐	☐
Runny Nose	☐	☐
Sinus Pressure	☐	☐
Other	_____	

Patient Signature: _____ Dr. Signature: _____ Date: _____

Today's Date: _____

Name: _____ Birth Date: _____

Have you ever had any of the following conditions?

(Please circle appropriate answers.)

High Blood Press Y N

Diabetes Y N If yes: Type 1 / Type 2

Thyroid Y N If yes: hyper / hypo

Arthritis Y N If yes: osteo / rheumatoid / other _____

Cancer Y N If yes, which type(s): _____

Stroke Y N

High Cholesterol Y N

ANY FAMILY HISTORY OF:

Lupus Y N Glaucoma Y N Relation: _____

MS Y N Macular Deg. Y N Relation: _____

Heart Disease Y N Cancer Y N Relation: _____

HIV Y N High BP Y N Relation: _____

Hepatitis Y N A / B / C Diabetes Y N Relation: _____

Shingles Y N Other (specify): _____ Relation: _____

Bell's Palsy Y N _____ Relation: _____

Asthma Y N **Do you currently smoke?** Y N How much? _____

COPD Y N **Have you ever smoked?** Y N If yes, when did you quit? _____

Kidney Disease Y N **Do you drink alcohol?** Y N How often? _____

Liver Disease Y N **Do you use recreational drugs?** Y N Which ones? _____

Crohn's/

Ulcerative Colitis Y N

Have you ever had a blood transfusion? Y N

Date of last flu shot: _____ Date of last Pneumococcal vaccine : _____

If you are 65 or older have you had 2 or more falls in the last year or any fall with injury in the last year: Y N

Please list any other medical and eye conditions for which you have been treated: _____

Please list all major surgeries and any eye surgeries: _____

Please list all allergies (to meds, foods, environs): _____

Patient

Signature: _____ **Dr. Signature:** _____ **Date:** _____



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Cancellation Policy

Our goal is to provide quality health care to all our patients in a timely manner. No-shows, late arrivals, and cancellations inconvenience not only our providers, but our other patients as well. Please be aware of our policy regarding missed appointments.

Appointment Cancellation

When you book your appointment, you are holding a space on our calendar that is no longer available to our other patients. In order to be respectful of your fellow patients, please call our office as soon as you know you will not be able to make your appointment.

If cancellation is necessary, we require that you call at least 24 hours in advance. Appointments are in high demand, and your advanced notice will allow another patient access to that appointment time.

Late Cancellations/No-Shows

A cancellation is considered late when the appointment is cancelled less than 24 hours before the appointed time. A no-show is when a patient misses an appointment without cancelling. In either case, we will charge the patient a **\$50.00** missed appointment fee.

For new patients' first appointments, a no show or late cancellation will result in a full charge of the new patient fee.