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
Lupus Y N
MS Y N
Heart Disease Y N
HIV Y N
Hepatitis Y N A / B / C
Shingles Y N
Bell's Palsy Y N

ANY FAMILY HISTORY OF:

Glaucoma Y N Relation:_____
Macular Deg. Y N Relation:_____
Cancer Y N Relation:_____
High BP Y N Relation:_____
Diabetes Y N Relation:_____
Other (specify): _____ Relation:_____
_____ Relation:_____

Asthma Y N
COPD Y N
Kidney Disease Y N
Liver Disease Y N
Crohn's/ Ulcerative Colitis Y N

Do you currently smoke? Y N How much? _____

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

Do you drink alcohol? Y N How often? _____

Do you use recreational drugs? Y N Which ones?_____

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.