

Dr. Anna Hess, OD

Marital Status: _____

Phone: _____ Work/Cell: _____

Referring Doctor: _____

[illegible][illegible]

PLEASE CHECK ANY CONDITIONS OR ILLNESSES YOU HAVE NOW OR EVER HAD						
Ear, Nose, Throat ➡	<input type="checkbox"/> Hard of Hearing	<input type="checkbox"/> Chronic Sinus	<input type="checkbox"/> Wears Hearing Aid(s)			<input type="checkbox"/> Other
Lung Disease: ➡	<input type="checkbox"/> Asthma	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Sleep Apnea		<input type="checkbox"/> Other
Heart Disease/Vascular ➡	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Heart Valve	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Arrhythmia		<input type="checkbox"/> Other
GI Disease ➡	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Colitis	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Gall Stones		<input type="checkbox"/> Other
Renal/Urinary Disease ➡	<input type="checkbox"/> Prostate	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Bladder	<input type="checkbox"/> Kidney		<input type="checkbox"/> Other
Musculoskeletal Disease ➡	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Lupus	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Fibromyalgia		<input type="checkbox"/> Other
Neoplastic/Cancer ➡	<input type="checkbox"/> Type					<input type="checkbox"/> Other
Endocrine Disease ➡	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Thyroid	<input type="checkbox"/> Pituitary			<input type="checkbox"/> Other
Neurologic Disease ➡	<input type="checkbox"/> Stroke	<input type="checkbox"/> Tumor	<input type="checkbox"/> Seizure	<input type="checkbox"/> Depression	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Other
Infectious Disease ➡	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> HIV	<input type="checkbox"/> Lyme Disease	<input type="checkbox"/> Sjogren's	<input type="checkbox"/> RA/JIA	<input type="checkbox"/> Other
Blood/Lymph ➡	<input type="checkbox"/> Anemia	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Bleeding			<input type="checkbox"/> Other

Patient Medical History

Dr. Denise Kerchner, MD

Dr. Brian Vitz, DO

Dr. Jacques Surer, DO

Dr. Anna Hess, OD

Childhood Developmental Illness — Please list

What prior surgeries have you had?

Ocular History

Active or past history of any eye conditions or disease such as glaucoma, cataracts, keratoconus, injuries or amblyopia?

Prior eye surgeries including laser procedures:

Do you wear glasses? ☐ Yes ☐ No If yes, how old are they? _____

Do you wear contact lenses? ☐ Yes ☐ No If yes, how old are they? _____

Do you know the brand of contact lenses you are wearing & where they were purchased? _____

When was your last eye exam? _____

Family Medical History

Please check any eye diseases or conditions that run in your family and indicate the relationship.

	Relationship		Relationship
<input type="checkbox"/> Glaucoma	_____	<input type="checkbox"/> Retinal Detachment	_____
<input type="checkbox"/> Cataract	_____	<input type="checkbox"/> Macular Degeneration	_____
<input type="checkbox"/> Lazy Eye	_____		

Check any other diseases or conditions that run in your family and indicate the relationship.

	Relationship		Relationship
<input type="checkbox"/> Heart	_____	<input type="checkbox"/> Neurologic	_____
<input type="checkbox"/> Arthritis	_____	<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> Cancer	_____		

Is there any other information we should know about your medical history? _____

Social History

What is your occupation? _____

What are your hobbies and activities? _____

Do you smoke? ☐ YES ☐ NO If yes, how many packs per day? _____ How many years? _____

Do you consume alcohol? ☐ YES ☐ NO If yes, how many drinks per day? _____ How many years? _____

Signature: _____ Date: _____

Preferred Language: _____

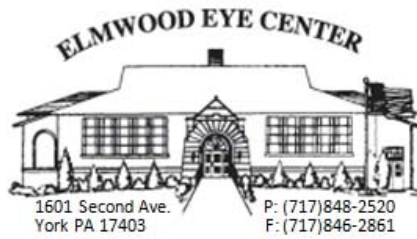
Please specify your ethnicity

Please specify your race

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Refused

☐ Asian
☐ Black or African American
☐ Hispanic
☐ Indian
☐ Multi-racial

☐ Native American Indian
☐ White
☐ Other Race
☐ Refused



Dr. Denise Kerchner, MD
Dr. Brian Vitz, DO
Dr. Jacques Surer, DO
Dr. Anna Hess, OD

At Elmwood Eye Center, our goal is to provide quality treatment and care in a timely matter to all of our patients.

Please be courteous and call our office promptly if you are unable to attend an appointment. Available appointments are in high demand and your early cancellation will give another person opportunity to have access to timely eye care.

We have implemented a cancellation and “No-show” policy which enables us to better utilize available appointments for our patients in need of eye care

Office Appointments and In-office Procedures:

Patients who fail to show to their scheduled appts or did not notify the office within **24 hours** shall be subject to a “No-show”/cancellation fee of \$25.

Surgeries:

Patients who fail to show/cancel their scheduled surgery and did not notify the office within 10 days of the scheduled surgery date, shall be subject to a “No-show/ cancellation fee” of \$100.00.

In the event of an emergency and early notice cannot be given, an exception may be granted.

Cancelled appointments due to insurance authorization denials are exempt from fees.

These “No-show/ cancellation” fees are not covered by insurances and are therefore the sole responsibility of the patient.

To cancel or reschedule your appointment, call 717-848-2520. If the call is not answered by a staff member, you may leave a message with your name, date of birth, appointment time and reason for the cancellation.