Packet Mail Date______________________ **Fact Sheet Return Date______________________**

PLEASE COMPLETE THE FOLLOWING AND RETURN AS SOON AS POSSIBLE TO THE FOUNDATION:

Benign Essential Blepharospasm Research Foundation, Inc.

BEBRF, Inc. (mailing address)
P. O. Box 12468
Beaumont, TX 77726-2468
Ph: (409) 832-0788

E-mail: bebrf@blepharospasm.org
Web Site: www.blepharospasm.org/

BEBRF, Inc. (street address)
637 N. 7th St., Suite 102
Beaumont, TX 77702
Fax: (409)832-0890

PLEASE PRINT **PLEASE PRINT** **PLEASE PRINT** **PLEASE PRINT**

NAME____

ADDRESS____

CITY/STATE/ZIP____

HOME PH: ______________________________ E-MAIL:______________________________

AGE_________ MARITAL STATUS______________ SPOUSE'S NAME______________________________

DIAGNOSIS: PLEASE CHECK APPROPRIATE BOX [ ] BLEPHAROSPASM [ ] MEIGE [ ] BOTH BEB/MEIGE

[ ] HEMIFACIAL SPASM [ ] OTHER (PLEASE EXPLAIN)______________________________

AGE AT ONSET ______________________________ WHERE DIAGNOSED______________________________

WHEN DIAGNOSED______________________________ DIAGNOSED BY WHOM______________________________

TREATMENT: (PLEASE GIVE DATES AND DOCTORS NAME AND ADDRESS)

SURGERY ____

____

DRUGS ____

____

BOTULINUM TOXIN INJECTIONS ____

____

LIST ANY SPECIFIC DETAIL YOU FEEL IS IMPORTANT ____

____

DO YOU HAVE ADDITIONAL FAMILY MEMBERS AFFECTED? IF SO, WHOM, AND IN WHAT WAY? ____________________

____

____

HOW DID YOU LEARN OF THE FOUNDATION? ____

____

PLEASE USE THE REVERSE SIDE OF THIS SHEET FOR ADDITIONAL INFORMATION.

____

PLEASE GIVE US YOU DOCTOR'S NAME AND ADDRESS:

NAME:______________________________

TITLE: ______________________________

ADDRESS: ______________________________

TELEPHONE:______________________________

RECEIVED__________________________

PASSED TO__________________________

PROCESSED__________________________

STATUS __________________________