NEW PATIENT INFORMATION

DR. DAVIS **DR. ANDERSON** **DR. SLOWIK**

TODAY'S DATE _____

GENERAL PATIENT INFORMATION

PATIENTS NAME _____

Parents Name (for patients under 18) _____

Patient Address _____

City _____ State _____ Zip _____

PATIENT Date of Birth _____ ☐Male ☐ Female

Please check one (pertaining to patient) ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Home Phone # _____ Work Phone # _____ Cell # _____

Name of Spouse _____

GENERAL INFORMATION

Primary Care Physician Name _____

Phone _____

Address _____

City _____ State _____ Zip _____

Referring Physician Name _____

Phone # _____

Reason for Visit _____

_____

Allergies to Medications _____

Current Medications _____

_____

RESPONSIBLE PARTY FOR THE PAYMENT OF SERVICES

Name _____ Date of Birth _____

Relationship to Patient _____ Email Address _____

Address _____ City _____ State/Zip _____

INSURANCE INFORMATION

Insurance Name: _____

Primary Card Holder: _____ DOB: _____

Employer _____ Phone #: _____

Address _____ City _____ State/Zip _____

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the above doctor to furnish the insured's insurance company all information which said insurance company may request concerning my present claim.

AUTHORIZATION OF INSURANCE BENEFITS

I hereby assign to the doctor all money to which I am entitled for expense relative to the services performed from time to time, but not to exceed my indebtedness to said doctor. It is understood that any money received from the above named insurance company over and above my indebtedness will be refunded to me when my bill is paid in full. I understand I am financially responsible to said doctor for charges.

PRINT NAME _____

RESPONSIBLE PARTY'S SIGNATURE _____

PATIENT'S SIGNATURE (IF OVER 18 YRS OLD) _____

Office Policies

Effective January 1, 2019

Payment

Payment in full for your insurance co-payment is due at the time of your visit, unless other arrangements have been made with the billing department. Please be prepared to pay. We accept the following forms of payment:

- Cash, Check, Visa or MasterCard

Insurance

Our office only accepts medical insurance policies. We do **not** accept any vision insurance. If your insurance has a vision plan, our office can print you a receipt for you to submit to your vision insurance.
If you cannot provide our office with an insurance card at the time of your appointment, you will be asked to pay in full for the office visit.
If your insurance is an HMO, you will need to provide a referral from your primary care doctor. If you do not have a referral with you at the time of your appointment, you will be asked to pay in full for the office visit.
If you do not have medical insurance, you will be responsible for payment in full for the office visit. Payment is due at the time services are rendered.

Minors

Payment for services of the treatment of minors is the responsibility of the adult accompanying that minor.

Missed Appointments

Once an appointment has been made, please remember that this time has been reserved for you. If you need to cancel or change an appointment, please contact our office to do so at least 24 hours before your scheduled appointment. If you miss a scheduled appointment or fail to notify us in advance, a missed appointment charge MAY be applied to your account.

Medical Record

To obtain a copy of your medical record or have a copy forwarded to another organization or person, please complete the Release of Medical Records form. A copy fee of $40 will be applied to your account. Once the form has been completed and payment has been accepted, your records will be released. Please allow one to two weeks for receiving records.

Patient Name: _____ DOB: _____
Please print

Patient Signature: _____ Date: _____

If patient is under 18 years of age:

Guardian Name: _____ Date: _____
Please Print

Guardian Signature: _____

EXPLANATION OF REFRACTIONS*

DR. DAVIS DR. ANDERSON DR. SLOWIK

Diagnostic Testing: Our office has discovered that the following diagnostic test is not covered by Medicare and most Medical Insurances; therefore, we must charge a fee of $45.00 for this diagnostic test.

* Refraction is the process of determining if there is a need for corrective eyeglasses or contact lenses. It is an essential part of an eye examination and necessary in order to write a prescription for glasses or contact lenses.

THE CHARGE FOR AN EYEGLASS PRESCRIPTION IS: $45**

**If you purchase Eyeglasses with our Optical Department this fee will be waived

If I understand that I am responsible for this diagnostic refracting fee, if performed. It is payable at the time of service. We can, at your request, file your refraction charge with your insurance plan. If your insurance policy pays this fee, we will then refund your payment.

_____ _____

Patient/Guardian Signature Date

EXPLANATION OF CONTACT LENS FITTING AND ANNUAL MAINTENANCE FEES

To our patients currently wearing contact lenses and patients interested in contact lenses.

With each annual visit, it is necessary to take measurements of the eye in order to properly prescribe contact lenses. There is a separate charge for this portion of the exam. The fee for contact lens fittings vary depending on which lens is prescribed.

Initial Contact Lens Fitting & Exam: $100.00
Annual Contact Lens Maintenance Exam: $75.00

Medical insurance does not cover this portion of the exam.
For patients who carry a separate vision plan, our office will provide you with a statement showing your payment of services, which you can submit.

_____ _____
Patient/Guardian Signature Date

NEW PATIENT INFORMATION

TODAY'S DATE _____

MEDICAL INFORMATION

Do you have high blood pressure? ☐ Yes ☐ No

If yes, is it under control with medications? _____

Do you have Diabetes? ☐ Yes ☐ No Medications? _____ Insulin? _____

Date last seen for blood pressure/diabetes _____ Under Control? _____

Do you have an autoimmune disease? List: _____

WORKERS COMPENSATION

Complete only in the case of a workers compensation claim.

Name of Company _____ Phone # _____

Address _____

Name of Supervisor _____

Date of Injury _____ Claim # _____

PATIENT MEDICAL HISTORY

WELCOME TO PROGRESSIVE EYE CARE

This is a questionnaire pertaining to your medical history. This information is key in providing you with the best care during your visit(s). Please fill out to the best of your ability. Thank you.

Allergies to Medicines
List all allergies to medications:

_____

_____

_____

Review of Systems
Please check **YES** or **NO**, in bold boxes, if yes, specify in small boxes and explain.

	YES	NO	EXPLANATION OF PROBLEM
Constitutional Symptoms……...	☐	☐	(If no, proceed to next topic)
Fever……....	□	□	
Weight Loss…….	□	□	
Other…….	□	□	
Eyes……..	☐	☐	(If no, proceed to next topic)
Blurry vision……..	□	□	
Burning……..	□	□	
Chronic infection of eyes or lids……	□	□	
Distorted vision…….	□	□	
Double vision……	□	□	
Dryness……	□	□	
Excess tearing/watering……	□	□	
Fluctuating visual acuity…….....	□	□	
Foreign body sensation……..	□	□	
Glare/light sensitivity…….....	□	□	
Itching…….	□	□	
Loss of side vision…….....	□	□	
Loss of vision…….....	□	□	
Mucous discharge…….....	□	□	
Occasional tearing……..	□	□	
Pain or soreness……..	□	□	
Redness…….	□	□	
Sandy or gritty feeling……..	□	□	
Sty, Chalazion……..	□	□	
Tired eyes……	□	□	
Other……..	□	□	
Are you having any difficulty?			
Reading small print…….....	□	□	
Reading in general……	□	□	
Recognizing people when close……	□	□	

Eyes Continued	**YES**	**NO**	**EXPLANATION OF PROBLEM**
Seeing to go up and down steps or curbs.	□	□	
Driving in bright light…….	□	□	
Driving in the dark…….	□	□	
Reading street/traffic signs……..	□	□	
Doing fine handiwork……	□	□	
Writing (checks, cards, etc.)……	□	□	
Playing games (bingo, cards, etc.)…….	□	□	
Playing sports (golf, tennis)…….	□	□	
Doing hobbies……	□	□	
Watching TV/Movies…….	□	□	
Are you satisfied with your present vision?.....	□	□	
Other…….	□	□	

	YES	**NO**	When diagnosed	Treatment	Family Member (Relationship)
Cataract	□	□			
Glaucoma	□	□			
Eye Muscle Problems	□	□			
Retina Problems	□	□			
Cancer	□	□			
Night Blindness	□	□			
Eyelid	□	□			
Other	□	□			

Current Eye Medications

Eye Problem(s) _____ Name of Medication(s) _____

_____ _____

_____ _____

Past Eye Surgery

Date(s) _____ Operation(s) _____

_____ _____

_____ _____

	YES	**NO**	**EXPLANATION OF PROBLEM**
Ears, Nose, Mouth, Throat……..……...	**☐**	**☐**	(If no, proceed to next topic)
Hearing problems…….	□	□	
Sinus Congestion…….	□	□	
Runny Nose……..	□	□	
Post-nasal drip……..	□	□	
Chronic cough……..	□	□	
Dry throat/mouth……..	□	□	
Other……..	□	□	
Cardiovascular……..	**☐**	**☐**	(If no, proceed to next topic)
Congestive heart failure……..	□	□	
Heart murmur……	□	□	
Heart Attacks……	□	□	
Irregular/fast heartbeat……	□	□	
Blood Pressure…….	□	□	
Chest pain/angina……	□	□	
Other……..	□	□	

Cardiovascular continued

Surgery (describe) _____

_____

_____

	YES	NO	EXPLANATION OF PROBLEM
Respiratory (Lungs/Breathing)……	☐	☐	(If no, proceed to next topic)
Asthma……..	☐	☐	_____
Emphysema……..	☐	☐	_____
Tuberculosis……..	☐	☐	_____
Lung Cancer…….	☐	☐	_____
Sarcoidosis……	☐	☐	_____
Other……..	☐	☐	_____
Surgery	_____		
	_____		
Gastrointestinal (Stomach/Intestines)……..	☐	☐	(If no, proceed to next topic)
Jaundice……..	☐	☐	_____
Ulcers/Bleeding……	☐	☐	_____
Hiatal Hernia…….	☐	☐	_____
Cancer……	☐	☐	_____
Other……..	☐	☐	_____
Surgery	_____		
	_____		
Genitourinary (Genitals/Kidney/Bladder)…..	☐	☐	(If no, proceed to next topic)
Kidney Disease…….	☐	☐	_____
Prostate cancer……	☐	☐	_____
Cervical/Uterine/Ovarian/Breast Cancer……..	☐	☐	_____
Pregnant now?.....	☐	☐	_____
Surgery	_____		
	_____		
Integumentary (Skin and/or Breast)	☐	☐	(If no, proceed to next topic)
Skin disease…….	☐	☐	_____
Skin cancer……	☐	☐	_____
Breast disease……..	☐	☐	_____
Breast cancer……	☐	☐	_____
Other……..	☐	☐	_____
Surgery	_____		
	_____		
Musculo-Skeletal……..	☐	☐	(If no, proceed to next topic)
Degenerative arthritis…….	☐	☐	_____
Rheumatoid arthritis…….	☐	☐	_____
Lupus…….	☐	☐	_____
Cancer……	☐	☐	_____
Other……..	☐	☐	_____
Surgery	_____		
	_____		

	YES	NO	EXPLANATION OF PROBLEM
Neurological……..	☐	☐	(If no, proceed to next topic)
Fainting……..……..	□	□	
Dizziness……..	□	□	
Migraines……...	□	□	
Convulsions/Seizures/Epilepsy……..	□	□	
Stroke/Paralysis……	□	□	
Benign tumor…….	□	□	
Cancer……	□	□	
Alzheimer's……	□	□	
Other……..	□	□	
Surgery			

Psychiatric……..……..	☐	☐	(If no, proceed to next topic)
Depression……..……	□	□	
Schizophrenia……..…….	□	□	
Other……..	□	□	

Hematologic/Lymphatic……..	☐	☐	(If no, proceed to next topic)
Anemia…..……..……	□	□	
Sickle Cell disease..…….	□	□	
Bleeding disorder…….	□	□	
Leukemia……...	□	□	
Blood Cancer……	□	□	
Swelling…….	□	□	
Lymph nodes……	□	□	
Surgery			

Allergic/Immunologic……..	☐	☐	(If no, proceed to next topic)
Head allergy symptoms……	□	□	
Seasonal symptoms……	□	□	
Hay fever symptoms……	□	□	
Immune problems……	□	□	
General allergies……..	□	□	
Other……	□	□	
Surgery			

Endocrine……..……..	☐	☐	(If no, proceed to next topic)
Diabetes……..……	□	□	
Cancer-pancreas/adrenal glands..……	□	□	
Thyroid problems……..	□	□	
Thyroid cancer……..	□	□	
Hormone Replacement Therapy……	□	□	
Other……..	□	□	
Surgery			

	YES	NO	EXPLANATION OF PROBLEM
Auto Immune Disease……..	☐	☐	
Other _____	☐	☐	_____
_____	☐	☐	_____
_____	☐	☐	_____

Past, Family, Social History

Past History
Describe any other problems, illnesses, surgeries or medications that were not described in the above questions.

_____
_____
_____
_____

Family History
Describe any major illnesses or hereditary problems of parents, grandparents or brothers/sisters.

_____
_____
_____
_____

Social History…	YES	NO	EXPLANATION
Drugs	☐	☐	_____
Alcohol	☐	☐	_____
Smoking	☐	☐	_____
Occupational	☐	☐	_____
Recent Voyages	☐	☐	_____
Other	☐	☐	_____

Date: _____ Patient Signature: _____

Date: _____ Technician Signature: _____

Date: _____ Physician Signature: _____

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

THE NOTICE OF PRIVACY PRACTICES IS AVAILABLE TO READ AND REVIEW AT THE FRONT DESK AND IN THE WAITING ROOM AREAS.

PROGRESSIVE EYE CARE WILL PROVIDE YOU WITH A COPY UPON REQUEST.