

NEW PATIENT INFORMATION

DR. PATRICIA DAVIS, M.D.

TODAY'S DATE _____

GENERAL PATIENT INFORMATION

PATIENTS NAME _____

PATIENT Date of Birth _____ Male Female

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

PATIENT Address _____

City _____ State _____ Zip _____

RESPONSIBLE PARTY (for patients under 18) _____

Home # _____

Cell # _____

EMAIL(print) _____

Name of Spouse _____

GENERAL INFORMATION

Referring Physician Name _____

Phone # _____

Primary Care Physician Name _____

Phone _____

Address _____

City _____ State _____ Zip _____

Reason for Visit _____

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, 2023

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 of \$50.00 will 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. For a personal copy of your records a copy fee of \$25.00 will be applied to your account for the first 25 pages, then \$1.00 for each additional page over 25. All medical records to another physician, faxed, will be free of charge. 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/Guardian: _____
Please print

DOB: _____

Patient Signature/Guardian: _____

Date: _____



EXPLANATION OF REFRACTIONS*

DR. DAVIS

Diagnostic Testing: Our office has discovered that the following diagnostic test, REFRACTION, 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 EYEGLOSS 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: \$175.00

Annual Contact Lens Maintenance Exam: \$125.00

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: _____

Please print all medicine you are currently taking:

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	<input type="checkbox"/>	<input type="checkbox"/>	(If no, proceed to next topic)
Fever.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Weight Loss.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	(If no, proceed to next topic)
Blurry vision.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Burning.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic infection of eyes or lids.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Distorted vision.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Double vision.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dryness.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Excess tearing/watering.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fluctuating visual acuity.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Foreign body sensation.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glare/light sensitivity.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Itching.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loss of side vision.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loss of vision.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mucous discharge.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Occasional tearing.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pain or soreness.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Redness.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sandy or gritty feeling.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sty, Chalazion.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tired eyes.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are you having any difficulty?			
Reading small print.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Reading in general.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Recognizing people when close.....	<input type="checkbox"/>	<input type="checkbox"/>	_____

Eyes Continued

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

	YES	NO	When diagnosed	Treatment	Family Member (Relationship)
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Eye Muscle Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Retina Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Night Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Eyelid	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____

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.....	<input type="checkbox"/>	<input type="checkbox"/>	(If no, proceed to next topic)
Hearing problems.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sinus Congestion.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Runny Nose.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Post-nasal drip.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic cough.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dry throat/mouth.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other.....	<input type="checkbox"/>	<input type="checkbox"/>	_____

	YES	NO	EXPLANATION OF PROBLEM
Cardiovascular.....	<input type="checkbox"/>	<input type="checkbox"/>	(If no, proceed to next topic)
Congestive heart failure.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart murmur.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Attacks.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Irregular/fast heartbeat.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chest pain/angina.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other.....	<input type="checkbox"/>	<input type="checkbox"/>	_____

Cardiovascular continued

Surgery (describe) _____

	YES	NO	EXPLANATION OF PROBLEM
Respiratory (Lungs/Breathing).....	<input type="checkbox"/>	<input type="checkbox"/>	(If no, proceed to next topic)
Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emphysema.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lung Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sarcoidosis.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Surgery _____			_____

Gastrointestinal (Stomach/Intestines).....	<input type="checkbox"/>	<input type="checkbox"/>	(If no, proceed to next topic)
Jaundice.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ulcers/Bleeding.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hiatal Hernia.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Surgery _____			_____

Genitourinary (Genitals/Kidney/Bladder).....	<input type="checkbox"/>	<input type="checkbox"/>	(If no, proceed to next topic)
Kidney Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Prostate cancer.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cervical/Uterine/Ovarian/Breast Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pregnant now?.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Surgery _____			_____

Integumentary (Skin and/or Breast)	<input type="checkbox"/>	<input type="checkbox"/>	(If no, proceed to next topic)
Skin disease.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin cancer.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Breast disease.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Breast cancer.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Surgery _____			_____

Musculo-Skeletal.....	<input type="checkbox"/>	<input type="checkbox"/>	(If no, proceed to next topic)
Degenerative arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rheumatoid arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Surgery _____			_____

	YES	NO	EXPLANATION OF PROBLEM
Neurological	<input type="checkbox"/>	<input type="checkbox"/>	(If no, proceed to next topic)
Fainting.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dizziness.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Migraines.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Convulsions/Seizures/Epilepsy.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke/Paralysis.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Benign tumor.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Alzheimer's.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Surgery _____			_____

Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	(If no, proceed to next topic)
Depression.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Schizophrenia.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other.....	<input type="checkbox"/>	<input type="checkbox"/>	_____

Hematologic/Lymphatic	<input type="checkbox"/>	<input type="checkbox"/>	(If no, proceed to next topic)
Anemia.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sickle Cell disease.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bleeding disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Leukemia.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Swelling.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lymph nodes.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Surgery _____			_____

Allergic/Immunologic	<input type="checkbox"/>	<input type="checkbox"/>	(If no, proceed to next topic)
Head allergy symptoms.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seasonal symptoms.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hay fever symptoms.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Immune problems.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
General allergies.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Surgery _____			_____

Endocrine	<input type="checkbox"/>	<input type="checkbox"/>	(If no, proceed to next topic)
Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer-pancreas/adrenal glands.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid problems.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid cancer.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hormone Replacement Therapy.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Surgery _____			_____

	YES	NO	EXPLANATION OF PROBLEM
Auto Immune Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	
..	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	

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	<input type="checkbox"/>	<input type="checkbox"/>	
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	
Smoking	<input type="checkbox"/>	<input type="checkbox"/>	
Occupational	<input type="checkbox"/>	<input type="checkbox"/>	
Recent Voyages	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	

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.