PROGRESSIVE
EYE CARE

WILLIAM E. KIMBALL, O.D. VICTOR A. RICHARDSON, O.D. LIANN H. KIMBALL, O.D.

PATIENT INFORMATION

PROGRESSIVE EYE CARE
WELCOMES YOU TO OUR OFFICE!

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

INSURANCE INFORMATION: (please give insurance card to receptionist)

PATIENT'S NAME _____ BIRTHDATE _____

INSURED'S NAME ** _____ INSURED'S DOB _____

*(**If insured's address is different from responsible party's address, please provide information in the space provided. Thank You.)*

RESPONSIBLE PARTY FOR THIS ACCOUNT _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

EMAIL _____

One Reservoir Office Park • Suite 304
1449 Old Waterbury Road
Southbury, CT 06488
(203) 267-2020
Email: progressiveeyecare@yahoo.com

Waterside 6 Office Park
20 Waterside Drive • Suite 102
Farmington, CT 06032
(860) 674-0307
Email: progressiveeyecare2@yahoo.com

Medical History Questionnaire

Name: _____ Today's Date: _____ / _____ / _____

Address: _____ Phone: _____

City: _____ Zip: _____ Work Phone: _____

Guardian (If Applicable): _____ Occupation: _____

Birth Date: _____ / _____ / _____ Social Security #: _____ / _____ / _____ Last Eye Exam: _____ / _____ / _____

E-Mail: _____ Dr.'s Phone: _____

I identify as: Male _____ Female _____ Non-binary _____ Last Medical Exam: _____ / _____ / _____

Medical History

Do you have any allergies to medications? ❒ no ❒ yes If yes, explain: _____

_____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

_____

_____

_____

List all major injuries, surgeries and/or hospitalizations you have had: _____

_____

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury: _____

Are you pregnant and/or nursing? ❒ no ❒ yes

Do you wear glasses? ❒ no ❒ yes If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? ❒ no ❒ yes If yes, how old is your present pair of lenses? _____

Type of contact lenses: ❒ Rigid ❒ Soft ❒ Extended Wear ❒ Other Are they comfortable? ❒ yes ❒ no

Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	❒	❒	❒	_____
Cataract	❒	❒	❒	_____
Crossed Eyes	❒	❒	❒	_____
Glaucoma	❒	❒	❒	_____
Macular Degeneration	❒	❒	❒	_____
Retinal Detachment/Disease	❒	❒	❒	_____
Arthritis	❒	❒	❒	_____
Cancer	❒	❒	❒	_____
Diabetes	❒	❒	❒	_____
Heart Disease	❒	❒	❒	_____
High Blood Pressure	❒	❒	❒	_____
Kidney Disease	❒	❒	❒	_____
Lupus	❒	❒	❒	_____
Thyroid Disease	❒	❒	❒	_____
Other _____	❒	❒	❒	_____

* *Please turn this form over and complete side two* *

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

☐ Yes, I would prefer to discuss my Social History information directly with my doctor. (Check box)

Do you drive? ☐ no ☐ yes If yes, do you have visual difficulty when driving? ☐ no ☐ yes If yes, please describe:

Do you use tobacco products? ☐ no ☐ yes If yes, type/amount/how long: _____

Do you drink alcohol? ☐ no ☐ yes If yes, type/amount/how long: _____

Do you use illegal drugs? ☐ no ☐ yes If yes, type/amount/how long: _____

Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis

Review of Systems

Do you currently, or have you ever had any problems in the following areas:

SYSTEM	NO	YES	?
CONSTITUTIONAL			
Fever, Weight Loss/Gain	☐	☐	☐
INTEGUMENTARY (Skin)	☐	☐	☐
NEUROLOGICAL			
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
EYES			
Loss of Vision	☐	☐	☐
Blurred Vision	☐	☐	☐
Distorted Vision/Halos	☐	☐	☐
Loss of Side Vision	☐	☐	☐
Double Vision	☐	☐	☐
Dryness	☐	☐	☐
Mucous Discharge	☐	☐	☐
Redness	☐	☐	☐
Sandy or Gritty Feeling	☐	☐	☐
Itching	☐	☐	☐
Burning	☐	☐	☐
Foreign Body Sensation	☐	☐	☐
Excess Tearing/Watering	☐	☐	☐
Glare/Light Sensitivity	☐	☐	☐
Eye Pain or Soreness	☐	☐	☐
Chronic Infection of Eye or Lid	☐	☐	☐
Sties or Chalazion	☐	☐	☐
Flashes/Floaters in Vision	☐	☐	☐
Tired Eyes	☐	☐	☐
ENDOCRINE			
Thyroid/Other Glands	☐	☐	☐

	NO	YES	?
EARS, NOSE, MOUTH, THROAT			
Allergies/Hay Fever	☐	☐	☐
Sinus Congestion	☐	☐	☐
Runny Nose	☐	☐	☐
Post-Nasal Drip	☐	☐	☐
Chronic Cough	☐	☐	☐
Dry Throat/Mouth	☐	☐	☐
RESPIRATORY			
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
VASCULAR / CARDIOVASCULAR			
Diabetes	☐	☐	☐
Heart Pain	☐	☐	☐
High Blood Pressure	☐	☐	☐
Vascular Disease	☐	☐	☐
GASTROINTESTINAL			
Diarrhea	☐	☐	☐
Constipation	☐	☐	☐
GENITOURINARY			
Genitals/Kidney/Bladder	☐	☐	☐
BONES / JOINTS / MUSCLES			
Rheumatoid Arthritis	☐	☐	☐
Muscle Pain	☐	☐	☐
Joint Pain	☐	☐	☐
LYMPHATIC / HEMATOLOGIC			
Anemia	☐	☐	☐
Bleeding Problems	☐	☐	☐
ALLERGIC / IMMUNOLOGIC	☐	☐	☐
PSYCHIATRIC	☐	☐	☐

If you answered YES to any of the above or have a condition not listed, please explain & list medications:

_____

_____

_____

_____

_____

_____ _____

Doctor's Signature Date

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"Routine" exams and all contact lens related services are frequently not covered by Medicare. Most insurance plans do not cover contact lens related services.

Managed care plans require referrals from your primary care physician to cover certain services. It is the patient's responsibility to obtain these in advance.

Medicare does not cover refractions, which are a necessary part of an eye examination.

Vision Insurance (such as VSP, etc.) covers *only* "Routine" services. If there are any medical conditions affecting the eyes that are pre-existing or become evident during the examination, such as diabetes, hypertension, dry-eyes, glaucoma, etc - this may require a more extensive examination and/or treatment. In this case, we may need to submit a claim to your health insurance plan as these conditions are not considered "Routine" in nature. Please initial here that you have read & understand this statement: _____ .

I understand that I am fully responsible for the payment of all fees for products and services not covered by my insurance plan and for any deductibles, co-payments, or co-insurance. Payments are due at the time that services are provided and when products are ordered. Unpaid balances incur a finance charge of 1 ½ % per month after 30 days and are referred for collection after 90 days.

I agree to pay all interest, collection charges and/or attorney's fees on past due balances. I have read and understood the above.

_____ _____

Patient's Signature Date

____ I understand that my medical records are confidential. I understand that by signing this consent form I am allowing my medical information to be released to my insurance company upon its request. I also understand that I may revoke this consent by a written request, at any time, with this doctor. If revoked, it is understood by all parties that all information released prior to being notified of such revocation was made with my consent.

____ I authorize payment of my medical benefits directly to Progressive Eye Care.

_____

Patient's Signature

HIPAA PRIVACY NOTICE

I, _____, have been shown the Notice of Privacy Policy (the
(Print full name of patient or legal representative)

"Policy") of Progressive Eye Care (the "Provider"), and have been offered a copy of such policy to keep for my records.

_____

Signature of Patient Date

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I hereby give Progressive Eye Care permission to speak with the following individual(s) regarding my personal medical information.

1) _____ (relationship) _____
2) _____ (relationship) _____
3) _____ (relationship) _____

Patient or Responsible Party Signature: _____

Cancellation/Missed Appointments

Our goal is to provide quality medical care in a timely manner. In order to be respectful of the medical needs of other patients, please be courteous and call us if you are unable to make your appointment.

If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance.

I understand that failure to provide adequate cancellation notice of at least 24 hours or missing scheduled appointments will result in a fee of $50 billed to my account.

Patient or Responsible Party Signature: _____

Date: _____

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Review of Medication History

I hereby give Progressive Eye Care permission to review my Electronic Medication Database.

By reviewing this database eye doctors are alerted to potentially harmful ocular side effects from your medications. It also limits the potential for adverse drug interactions.

This consent will remain effective until withdrawn.

Patients Name: _____

Patient/Responsible Party Signature: _____

Date: _____

Pharmacy Name: _____

Address: _____

City: _____

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CREDIT CARD ON FILE POLICY

As you know, the medical landscape has become more and more burdensome to navigate, with greater cost sharing every year. In order to continue providing the kind of care our patients deserve, it has become necessary to require a credit card/HSA/FSA card be left on file to cover any balance due to deductibles, coinsurance, copays, lack of coverage or payment failure.

Your credit information is kept completely confidential and secure. Your balance will be billed to your card only AFTER your insurance company has processed your claim and paid their portion. We will call to notify you of the amount we will apply to your card.

I authorize Progressive Eye Care to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

□Visa □Mastercard □Discover □HSA □FSA

Credit Card Number_____

Expiration Date _____ / _____ / _____

Cardholder Name _____

I, the undersigned, authorize and request Progressive Eye Care to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility.

This authorization will remain in effect until I cancel this authorization. To cancel, I must provide notification to Progressive Eye Care in writing and the account must be in good standing.

Patient Name(Print):_____

Patient Signature:_____

Date:_____ / _____ / _____

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