Dr. Catherine A. Kennedy, OD, FCOVD
Developmental and Behavioral Optometrist
83 Cambridge Street, Suite 1D
Burlington, MA 01803
781-272-2187 fax 781-229-0869

WELCOME TO OUR OFFICE

We look forward to meeting you.

Doctor Kennedy is looking forward to providing you with high quality personalized care. Your appointment time is reserved specifically for you. We do not overbook in anticipation of a cancellation or no-show. The doctor's emphasis is to maximize your success.

PLEASE FILL OUT THE ENCLOSED HISTORY FORM. You may email or fax it to us prior to your appointment or bring it with you. Copies of previous evaluations and reports may be faxed or brought with you.

Please bring any eyeglasses *and/or contact lenses (and the contact lens prescription) with you.*

PAYMENT POLICY

In order to provide this high quality personalized service, we are not affiliated with any insurance plan and provide service on a private pay basis only. Payment of the evaluation fee will be expected in full at the time of service. Your insurance company may cover our services and we encourage you to seek reimbursement. We will provide you with a detailed receipt to submit to your insurance company.

REASON FOR VISIT: check all that apply

___work related vision problem

___eye teaming problem (turned eye lazy eye)

___myopia control/reduction

___sports vision enhancement

___vision problems after brain injury

___interest in Optometric Vision Therapy

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SPECIALIZING IN LEARNING RELATED VISION PROBLEMS and BINOCULAR VISION PROBLEMS

Please provide the following information as completely as possible. Use the back side of page if needed.

NAME(first, middle, last):_____

Prefers to be called:_____

ADDRESS:_____
street town zip

HOME PHONE:_____OTHER PHONE:_____(work) (cell)

Date of Birth:_____Occupation:_____

EMAIL ADDRESS:_____

Do you need a written report?_____(will be emailed to you)

Referred By:_____ or How Did You Hear About Dr. Kennedy?

Present Situation:
In what way do you seem to have visual difficulty?

Are you currently receiving medical care /physical therapy/occupational therapy/speech-auditory therapy/complementary(alternative) therapy for any conditions? Please list the treatment and the diagnosis. Also include any medications or remedies. If there has been previous treatment or school-based care please note that also.

Is there any history of head injury, falls, accidents or serious wounds in the head/neck/back area? If so please describe.

Do you have allergies? yes___ no___

Visual History
How long has visual difficulty been noticed?_____

Has there been previous visual care?_____ If so, please detail below:
Doctor's Name Approximate Date Result

Please note, Dr. Kennedy is not affiliated with any insurance plan and provides service on a private pay basis only. Payment is expected in full at the time of service. Check, cash, or credit card accepted. Your insurance company may cover our services and we encourage you to seek reimbursement. We will provide you with a detailed receipt you may submit with your insurance claim.

Signature:_____ Date:_____