CENTRAL DAKOTA EYECARE / **Patient Demographic**

Patient Name:_____ Male / Female

FIRST M.I. LAST

Date of Birth: _____ Age:_____ S.S. #_____

Address: _____

MAILING ADDRESS CITY STATE ZIP

Email:_____

Phone #: HOME: _____WORK: _____CELL:_____

Employer:_____ Marital Status:_____

Name of Bill to:_____ Birth Date:_____

Patient Relationship to Bill to: Self Spouse Child Other_____

Name of Spouse (or parent / bill to, if patient is a dependent)_____

Medical Information may also be shared with the following family members and/or caregivers:

Name: _____ Relationship to Patient:_____

Name: _____ Relationship to Patient:_____

Note: Limitations on sharing your medical information may be indicated on your signed notice of privacy practices acknowledgement form

Emergency Contact: _____ Relationship:_____ Phone:_____

Preferred Language_____ Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race ☐ American Indian/Alaskan Indian ☐ Asian ☐ Black or African American
☐ Native Hawaiian or other Pacific Islander ☐ White

Insurance Information

1. Name of Ins_____
   Member ID# _____
   Group # _____
   Policy Holder_____DOB_____
   Relationship Self / Spouse / Parent

2. Name of Ins_____
   Member ID# _____
   Group # _____
   Policy Holder_____DOB_____
   Relationship Self / Spouse / Parent

I authorize Drs. Rausch, Eisnach, Hart, & Marso or their designee(s) to exchange information regarding my care and benefits with the above listed insurance company or companies for the purpose of collecting professional fees on my behalf. I assign all benefits payable to Drs. Rausch, Eisnach, Hart & Marso. To the best of my knowledge this Information is accurate as of this date. I accept full responsibility for all charges related to my treatment that are not covered by my insurance.

I acknowledge that I have been offered or have received a copy of Notice of Privacy Practices.

Signature of patient (or bill to)_____ Date_____

over ➔

SOCIAL HISTORY: *This information is kept strictly confidential. If you prefer to discuss this with your doctor, leave blank.*

Do you use tobacco products? ☐ No ☐ Yes If yes, kind/amount/how long? _____

Do you drink alcohol? ☐ No ☐ Yes If yes, kind/amount/how long? _____

Medical Doctor/Clinic: _____ Pharmacy: _____

PERSONAL 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 eye medications: _____

Height _____ Weight _____

Are you pregnant or nursing? ☐ No ☐ Yes

REVIEW OF SYSTEMS: *Do you currently have, or have you ever had, any problems in the following areas?*

	No	Yes		No	Yes
CONSTITUTIONAL			**RESPIRATORY**		
FEVER/WEIGHT GAIN	☐	☐	ASTHMA	☐	☐
INTEGUMENTARY			EMPHYSEMA	☐	☐
SKIN	☐	☐	**VASCULAR/CARDIOVASCULAR**		
NEUROLOGICAL			HEART/VASCULAR DISEASE	☐	☐
HEADACHES	☐	☐	HIGH BLOOD PRESSURE	☐	☐
EARS/NOSE/MOUTH/THROAT			**GASTROINTESTINAL**		
CONGESTION	☐	☐	STOMACH	☐	☐
CHRONIC COUGH	☐	☐	**GENITOURINARY**		
EYES			KIDNEY/BLADDER	☐	☐
CATARACTS	☐	☐	**BONES/JOINTS/MUSCLES**		
GLAUCOMA	☐	☐	JOINT PAIN/ARTHRITIS	☐	☐
LAZY EYE	☐	☐	**LYMPHATIC/HEMATOLOGIC**		
MACULAR DEGENERATION	☐	☐	BLEEDING PROBLEMS	☐	☐
DRY EYE	☐	☐	**PSYCHIATRIC**		
CROSSED EYES	☐	☐	DEPRESSION	☐	☐
ALLERGIC/IMMUNOLOGIC			**ENDOCRINE**		
SEASONAL ALLERGIES/HAY FEVER	☐	☐	DIABETES	☐	☐
ENVIRONMENTAL ALLERGIES	☐	☐	THYROID/OTHER GLANDS	☐	☐

OCULAR SURGERIES:

	Left Eye	Right Eye	Date of Surgery
LASIK	☐	☐	_____
CATARACTS	☐	☐	_____
MACULAR DEGENERATION	☐	☐	_____
RETINAL DETACHMENT	☐	☐	_____
OTHER	☐	☐	_____

FAMILY HISTORY: Please note any family history (Parents, Grandparents, siblings, children, or deceased)

Disease/Condition	No	Yes	Relationship to You
BLINDNESS	☐	☐	_____
GLAUCOMA	☐	☐	_____
MACULAR DEGENERATION	☐	☐	_____
DIABETES	☐	☐	_____
CATARACTS	☐	☐	_____