CENTRAL DAKOTA EYECARE

- PATIENT DEMOGRAPHIC -

Patient Name: _____ (CIRCLE ONE) Male / Female / Other
FIRST MIDDLE LAST

Date of Birth: _____ Age: _____ SSN: _____

Address: _____
MAILING ADDRESS CITY STATE ZIP

- CONTACT INFORMATION -

Phone #s: Cell: _____ Work: _____ Home: _____

Email: _____

Employer: _____

Marital Status: _____ Name of Spouse (if applicable): _____

Who to Bill: ◯Self ◯Spouse ◯Other _____
NAME & RELATIONSHIP

- INSURANCE INFORMATION -

Please provide valid insurance cards to staff to ensure proper billing

Primary Insurance Company: _____

Insurance Provided By: ◯Self or ◯Employer: _____

Secondary Insurance Company (if applicable): _____

Insurance Provided By: ◯Self or ◯Employer: _____

- IN CASE OF EMERGENCY -

Medical and/or billing information may be shared with the following individuals and/or facilities:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Any limitations or changes must be noted and submitted in writing for our records.

Emergency Contact: _____ Phone #: _____

- Collection of the following is encouraged by Federal Health Agencies -

Race: ◯American Indian/Alaskan Indian
◯Caucasian
◯African American
◯Asian
◯Native Hawaiian or Other Pacific Islander
◯Other

Preferred Language: ◯English
◯Spanish
◯Other

Ethnicity: ◯Hispanic or Latino
◯Not Hispanic or Latino

- ACKNOWLEDGMENT AND PATIENT FINANCIAL AGREEMENT -

I authorize Central Dakota Eyecare, LLP and their designees to exchange information regarding my care and benefits with my current insurance company or companies for the purpose of collecting professional fees on my behalf. I assign all benefits payable to Central Dakota Eyecare, LLP. 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 and acknowledge that it is my responsibility to know my benefits and coverage. I acknowledge that I have been offered a copy of Notice of Privacy Practices.

Signature of Patient or Responsible Party: _____ Date: _____

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

Do you use tobacco products? ◯YES ◯NO - If yes, kind/amount/how long?_____

Do you drink alcohol? ◯YES ◯NO - If yes, kind/amount/how long?_____

PERSONAL MEDICAL HISTORY:

Current Medical Doctor/Clinic: _____ Pharmacy: _____

Do you have any allergies to medications? ◯YES ◯NO - If yes, please explain: _____

_____

List any medications you currently take (*including oral contraceptives, aspirin, OTC medications and home remedies*):

_____

_____

List any eye medications currently used: _____

Height: _____ Weight: _____ Are you pregnant or nursing? ◯YES ◯NO

REVIEW OF SYSTEMS:

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

	YES	NO
CONSTITUTIONAL		
FEVER/WEIGHT GAIN	◯	◯
INTEGUMENTARY		
SKIN	◯	◯
NEUROLOGICAL		
HEADACHES	◯	◯
EARS/NOSE/MOUTH/ THROAT		
CONGESTION	◯	◯
CHRONIC COUGH	◯	◯
EYES		
CATARACTS	◯	◯
GLAUCOMA	◯	◯
LAZY EYE	◯	◯
MACULAR DEGENERATION	◯	◯
DRY EYE	◯	◯
CROSSED EYES	◯	◯
ALLERGIC/IMMUNOLOGIC		
SEASONAL ALLERGIES/HAY FEVER	◯	◯
ENVIRONMENTAL ALLERGIES	◯	◯

	YES	NO
RESPIRATORY		
ASTHMA	◯	◯
EMPHYSEMA	◯	◯
VASCULAR/CARDIOVASCULAR		
HEART/VASCULAR DISEASE	◯	◯
HIGH BLOOD PRESSURE	◯	◯
GASTROINTESTINAL		
STOMACH	◯	◯
GENITOURINARY		
KIDNEY/BLADDER	◯	◯
BONES/JOINTS/MUSCLES		
JOINT PAIN/ARTHRITIS	◯	◯
LYMPHATIC/HEMATOLOGIC		
BLEEDING PROBLEMS	◯	◯
PSYCHIATRIC		
DEPRESSION	◯	◯
ENDOCRINE		
DIABETES	◯	◯
THYROID/OTHER GLANDS	◯	◯

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

DISEASE/CONDITION	YES	NO	RELATIONSHIP TO YOU
BLINDNESS	◯	◯	_____
GLAUCOMA	◯	◯	_____
MACULAR DEGENERATION	◯	◯	_____
DIABETES	◯	◯	_____
CATARACTS	◯	◯	_____

OCULAR SURGERIES:

	LEFT EYE	RIGHT EYE	DATE OF SURGERY
LASIK	◯	◯	_____
CATARACTS	◯	◯	_____
MACULAR DEGENERATION	◯	◯	_____
RETINAL DETACHMENT	◯	◯	_____
OTHER	◯	◯	_____