



CENTRAL DAKOTA EYECARE

- PATIENT DEMOGRAPHIC -

CIRCLE ONE

Patient Name: _____ 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	Preferred Language:	English
	Caucasian		Spanish
	African American		Other
	Asian	Ethnicity:	Hispanic or Latino
	Native Hawaiian or Other Pacific Islander		Not Hispanic or Latino
	Other		

- 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

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

DISEASE/CONDITION	YES	NO	RELATIONSHIP TO YOU
BLINDNESS	<input type="radio"/>	<input type="radio"/>	_____
GLAUCOMA	<input type="radio"/>	<input type="radio"/>	_____
MACULAR DEGENERATION	<input type="radio"/>	<input type="radio"/>	_____
DIABETES	<input type="radio"/>	<input type="radio"/>	_____
CATARACTS	<input type="radio"/>	<input type="radio"/>	_____

OCULAR SURGERIES:

	LEFT EYE	RIGHT EYE	DATE OF SURGERY
LASIK	<input type="radio"/>	<input type="radio"/>	_____
CATARACTS	<input type="radio"/>	<input type="radio"/>	_____
MACULAR DEGENERATION	<input type="radio"/>	<input type="radio"/>	_____
RETINAL DETACHMENT	<input type="radio"/>	<input type="radio"/>	_____
OTHER	<input type="radio"/>	<input type="radio"/>	_____

REVIEW OF SYSTEMS:

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

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