

Eye Center of the Dakotas

WELCOME TO OUR OFFICE!

Please take a moment to share some information with us so we may better understand your eye care needs.

Date: _____ Last Name _____ First Name _____ MI _____
Address _____ City _____ State _____ Zip Code _____
Home Phone (____) _____ Work Phone (____) _____ SSN _____ - _____ - _____ E-mail _____
Date of Birth _____ Emergency Contact _____ Phone _____
Employer (or school) _____ Occupation (or grade) _____
Spouse's (or parent's) Name _____ Place of Employment _____
Primary Medical Insurance _____ Policy # _____
Secondary and/or Vision Insurance _____ Policy # _____
Family Physician/Clinic _____ Date of last physical _____

Current medications (RX or over-the-counter), please list:	Allergies to any medications, please list:
_____	_____
_____	_____
_____	_____

How did you choose our office for your needs?

If a referral, who may we thank for referring you to our office?
Name _____

FAMILY MEDICAL HISTORY
Is there family medical history of any of the following?
 Blindness Relation _____
 Cancer Relation _____
 Corneal Problems Relation _____
 Glaucoma Relation _____
 Lazy/Turned Eye Relation _____
 Macular Degeneration Relation _____
 Retinal Problems Relation _____
 Diabetes Relation _____
 Other _____

YOUR MEDICAL HISTORY
Do you have problems with any of the following systems:
 Gastrointestinal Nervous
 Ears/Nose/Throat Urinary
 Cardiovascular Muscles/Bones
 Respiratory Skin
 High blood pressure Eyes
 Endocrine (glands) Blood/Lymph
 Allergic/Immunologic Headaches
 Diabetes Mental
Type _____ Date of diagnosis _____
 Cancer
Type _____ Date of diagnosis _____
 Other, please explain _____

YOUR EYE HISTORY
Date of Last Eye Exam _____
Doctor/Clinic _____
What is the main reason for your visit today? _____

Any problems with your current glasses? _____

Have you ever been diagnosed or treated for any eye conditions?

Have you had any eye surgeries? _____
What are your hobbies? _____

Are you ordering glasses today?
 Yes No Only if prescription changes
Have you worn, or are you currently wearing contact lenses?

I understand that professional fees are due at the time services are rendered and that a 50% deposit is required at the time of order on all materials. Orders will be held for a maximum of 45 days. After this time, all orders will be returned to the lab and the deposit will be forfeited and not refunded.

I understand and agree that insurance payments are an arrangement between my insurance carrier and myself. I authorize this office to prepare any insurance forms to assist me in reimbursement from my insurance company. I authorize that payment be made directly to this office and be credited to my account upon receipt. I authorize this office to release any information required to process any insurance claims.

Signature _____ Date _____
(Parent or guardian if patient is a minor.)

Do you drink alcohol? yes (occasional, 1x day, 2-3 day, 4+ day)
 no
Do you smoke? yes (occasional, 1/2 pk. day, 1 pk. day, 1+ pk day)
 no