



NEW PATIENT FORM

Welcome to Dakota Vision Center of Sioux Falls. We are delighted to have you as a patient and we appreciate you choosing us for your eyecare needs. Please take a few moments to complete the following information.

Mr. Miss Mrs. Ms.
 Male Female

First Name _____ MI _____ Last Name _____ Preferred Name _____

Street Address _____ City _____ State _____ Zip _____

Social Security Number _____ Date of Birth _____ Home Phone & Area Code _____ Work Phone _____

Email Address _____ Spouse or Parent(s) Name _____ Person Responsible for Account _____

Emergency Contact _____ Emergency Phone _____

How Were You Referred To Our Office?

- Phone Book School Advertisement Patient (Please Name) _____
 Insurance Listing Drive By Other Doctor (Please Name) _____

PRIMARY INSURANCE INFORMATION

Name & Address of Primary Insurance Company _____ City _____ State _____ Zip _____

M F Insured's First Name _____ MI _____ Insured's Last Name _____

Insured's Identification Number _____ Group Number _____ Insured's Date of Birth _____

PATIENT RELATIONSHIP TO INSURED

- Self

Patient Status

- Single Married Other
 Full-Time Student Part-Time Student Employed

SECONDARY INSURANCE INFORMATION

Name & Address of Primary Insurance Company _____ City _____ State _____ Zip _____

M F Insured's First Name _____ MI _____ Insured's Last Name _____

Insured's Identification Number _____ Group Number _____ Insured's Date of Birth _____

Patient Relationship to Insured

- Self Spouse Child Other

PLEASE READ:

In order to control the cost of billing, we ask that the patient's portion is paid at the time service is rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and materials are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 day old are subject to collection fees. There will be a service charge for returned checks.

Payment from my insurance is to be paid directly to Dakota Vision Center of Sioux Falls. I understand that Vision Service Plan will be billed as my primary insurance. I understand that billing any secondary insurance is my responsibility. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

Signature _____ Date _____

PATIENT HISTORY AND INFORMATION

Primary Care Physician and Clinic Name _____

Primary Care Physician Street Address _____ City _____ State _____ Zip _____ Phone _____

REFERRING PHYSICIAN

Referring Physician and Clinic Name _____

Referring Physician Street Address _____ City _____ State _____ Zip _____ Phone _____

HEALTH HISTORY

What is the main reason for today's exam? _____ When was your last exam? _____

When was your last health exam? _____

Past Illnesses or Injuries: _____

Past Surgeries: _____

Current Medications: _____

Current Eye Drops: _____

Medicines that cause reactions or sensitivities: _____

Specific Allergies: _____

EYE HISTORY

Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dryness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Strabismus (Crossed Eyes)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cataract	<input type="checkbox"/> Yes <input type="checkbox"/> No	Excess Tearing / Watering	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blurred Vision Distance	<input type="checkbox"/> Yes <input type="checkbox"/> No
Macular Degeneration	<input type="checkbox"/> Yes <input type="checkbox"/> No	Eye Pain or Soreness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blurred Vision Near	<input type="checkbox"/> Yes <input type="checkbox"/> No
Retinal Detachment	<input type="checkbox"/> Yes <input type="checkbox"/> No	Foreign Body Sensation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Distorted Vision (Halos)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Color Blindness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Infection of Eye or Lid	<input type="checkbox"/> Yes <input type="checkbox"/> No	Double Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No
Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Itching	<input type="checkbox"/> Yes <input type="checkbox"/> No	Floaters or Spots	<input type="checkbox"/> Yes <input type="checkbox"/> No
Glare / Light Sensitivity	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mucous Discharge	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fluctuating Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tired Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Drooping Eyelid	<input type="checkbox"/> Yes <input type="checkbox"/> No	Loss of Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No
Amblyopia (Lazy Eye)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Redness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Loss of Side Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No
Burning	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sandy or Gritty Feeling	<input type="checkbox"/> Yes <input type="checkbox"/> No		

GENERAL HEALTH CONDITION

Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory (Asthma)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anxiety or Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No
Weight Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gastrointestinal	<input type="checkbox"/> Yes <input type="checkbox"/> No	Endocrine (Thyroid, Diabetes)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other Symptoms	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood / Lymph	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ear, Nose, Throat	<input type="checkbox"/> Yes <input type="checkbox"/> No	Muscles, Bones, Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Allergic	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiovascular (High Blood Pressure, Etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are You?	<input type="checkbox"/> Pregnant
		Neurological (Multiple Sclerosis)	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Nursing

FAMILY HISTORY

Amblyopia (Lazy Eye)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Retinal Detachment	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blindness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Strabismus (Eye Turn)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cataract	<input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lupus	<input type="checkbox"/> Yes <input type="checkbox"/> No
Color Blindness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Macular Degeneration	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other	<input type="checkbox"/> Yes <input type="checkbox"/> No

MEDICAL HISTORY QUESTIONNAIRE

SOCIAL HISTORY

Current Occupation _____ Years _____ Employer _____

SPECTACLE LENS HISTORY

Do you use a computer? Y N How many hours per day? _____ Distance from PC? _____

Do you drive? Y N Mileage to work each way? _____ Do you have glare problems? _____

Do you have visual difficulty when driving? Y N

Do you have problems with night vision? Y N

Do you currently wear glasses? Y N Since? _____
 Full-time Part-time Distance Close

Type of glasses owned:

Single Vision Bi-focals Tri-focals Backup Safety Sports Progressive

Have you had trouble in the past with glasses? Y N

Do you currently wear sunglasses? Y N Are you sunglasses your current perscription? Y N

SPECIAL EYEWARE NEEDS:

Computer (special perscriptions, special anti-glare tints or coatings) Safety Glasses (gardening, woodworking, welding)
 Occupational (mechanics, plumbers, pilots) Sports / Hobbies (racquet sports, motorcycling)

CONTACT LENS HISTORY

Have you ever tried to wear contacts? Y N Reason for stopping? _____

Do you currently wear contact lenses? Y N Since? _____

In not a contact lens wearer, are you interested in trying contact lenses at this time? Y N

Type and brand of contact lenses? _____ Today's wearing time? _____

How many hours per day? _____ How many days per week? _____

Please rate the following on a scale of 1 - 10, with 1 being **POOR** and 10 being **EXCELLENT**

	Right	Left		Right	Left		Right	Left
Lens Comfort	_____	_____	Distance Vision	_____	_____	Near Vision	_____	_____

What solutions do you use? Cleaner _____ Disinfectant _____ Enzyme _____

SOCIAL HISTORY

Do you use nutritional supplements (vitamins, etc.)? Y N

Do you engage in regular exercise: Y N

Do you drink alcohol? If yes, how much / often: No Occasionally 1 per day 2 - 3 per day 4+ per day

Do you smoke? If yes, how much / often: No Occasionally 1 / 2 pack 1 pack per day 1+ pack per day

Method of tobacco intake: Smoking Chewing

Do you use illegal drugs: Y N

Hobbies / Interests: _____

Last Health Exam: _____