General Information

Date: ____/____/____

Last Name_____ First Name: _____M _____DOB: ___/___/___

M or F SSN:_____/____/_____ Married / Single / Widowed / Domestic Partner

Address: _____ City: _____ State: _____ Zip: _____

Home Ph: ( ) _____ Work Ph: ( ) _____ Cell Ph: ( ) _____

Employer/School:_____ FT PT Occupation:_____

E-mail Address: _____ Sports/Hobbies: _____

Emergency Contact: _____ Relation: _____ Phone #: ( ) _____

Preferred Language: English Spanish Preferred Communication: Email Phone Postal

Race: Am. Indian Asian Black Hispanic Hawaiian/Pacific Island White

Ethnicity: Hispanic/Latino Hawaiin/ Pacific Island Not Hispanic/Latino

CASE HISTORY / REASON FOR VISIT:

Date of Last Medical Exam:___/___/___ Primary Physician/Clinic:_____

Date of Last Eye Exam:____/____/____ Clinic/Eye Doctor's Name:_____

Do you wear glasses: Yes No Full Time Reading only Driving only

Do you routinely wear sunglasses? Yes No Do you wear contact lenses?: Yes No

Are you interested in being fit with contact lenses? Yes No

Are you interested in refractive surgery or LASIK? Yes No

Have you ever had eye injuries? Yes No Which Eye?_____

Have you ever had eye surgeries? Yes No Why?_____

Have you used eye medication? Yes No Why?_____

Are you currently pregnant or nursing? Yes No N/A

Have you ever been diagnosed with?

Cataracts: Yes/No When were you diagnosed?_____

Glaucoma: Yes/No When were you diagnosed?_____

Macular Degeneration: Yes/No When were you diagnosed?_____

What are your visual symptoms: Please circle any that apply:

[ ] Blurred Vision/Distance
[ ] Blurred Vision/Near
[ ] Double Vision
[ ] Eye Strain or Tired Eyes
[ ] Eye Infections
[ ] Dry / Gritty Eyes
[ ] Red / Watery Eyes
] Eye Pain / Soreness
[ ] Wandering eye / crossed eye
[ ] Mucus Discharge
[ ] Headaches
[ ] Droopy Eyelid
[ ] Loss of Vision
] Floaters/Spots/Flashes
[ ] Light Sensitive

Please turn over and complete other side

PERSONAL MEDICAL HISTORY (REVIEW OF SYSTEMS) : PLEASE CHECK IF ANY OF THE FOLLOWING APPLIES TO YOU, AND LIST ANY MEDICATIONS FOR EACH CONDITION THAT YOU CHECK. IF YOU HAVE NONE OF THESE CONDITIONS, PLEASE CHECK NONE.

Cardiovascular: __ None ___ Hypertension ___ Stroke ___ Heart Disease ___ Vascular Disease ___High Cholesterol	Endocrine: ___ None ___ Non-Insulin Dependent Diabetes ___ Insulin Dependent Diabetes ___ Thyroid Problem ___ Hormonal Dysfunction ___ Other:	Respiratory: __ None ___ Asthma ___ Bronchitis ___ Emphysema ___ COPD ___ Other:
Constitutional: __ None ___ Cancer ___ Trauma/Large Volume Blood Loss ___ Developmental Disability ___ Other:	Ocular __ None ___ Glaucoma ___Macular Degeneration ___Detached Retina ___ Other:	Psychiatric: __ None ___ ADHD ___ Depression ___ Schizophrenia ___ Other:
Neurological: __ None ___ Multiple Sclerosis ___ Epilepsy ___ Cerebral Palsy ___ Tumor ___ Other:	Musculoskeletal: __ None ___ Osteoarthritis ___ Fibromyalgia ___ Muscular Dystrophy ___ Ankylosing Spondylitis ___ Other:	Immunologic: __ None ___ AIDS or HIV ___ Rheumatoid Arthritis ___ Lupus ___ Neurofibromatosis ___ Other:
Hematological: __ None ___ Anemia ___ Leukemia ___ Other:	Gastrointestinal __ None ___ Crohn's ___ Colitis ___ Other:	Ear/Nose/Throat: __ None ___ Hearing Loss ___ Upper Respiratory Infection ___ Other:
Dermatologic: __ None ___ Eczema ___ Rosacea ___ Psoriasis ___ Other:	Allergies (please list) __ None Drug: Environmental:	Alcohol Use: Y N Amount: Tobacco Use: Y N Amount:

Please list any medications and/or drugs that you are taking (including herbal) :

1 _____ For _____
2 _____ For _____
3 _____ For _____
4 _____ For _____
5 _____ For _____
6 _____ For _____
7 _____ For _____
8 _____ For _____
9 _____ For _____
10 _____ For _____

FAMILY HISTORY: Has anyone in your family (grandparents, parents, siblings, children, living or deceased) been diagnosed with:

DISEASE / CONDITION

Retinal Detachment: Yes/No _____
High Blood Pressure. Yes/No _____
Diabetes: Yes/No _____
Cancer: Yes/No _____
Heart Disease: Yes/No _____

Blindness: Yes/No _____
Cataracts: Yes/No _____
Glaucoma: Yes/No _____
Crossed Eyes: Yes/No _____
Macular Degeneratio Yes/No _____

Date:_____ Patient Sign:_____ Dr. review:_____Date:_____

Date:_____ Patient Sign: _____ Dr. Review:_____Date:_____

Date:_____ Patient Sign: _____ Dr. Review: _____Date:_____

DAKOTA EYE CARE ASSOCIATES

Date:_____

REQUIRED SIGNATURE FORM – All agreements are in effect until I chose to cancel them.

Name of Patient:_____ **DOB:**_____

Name of Insured:_____ **DOB:** _____

_____ **Initials: RECORD RELEASE:** I agree that my medical and/or billing information may be given to or sent to Dakota Eye Care Associates, my referring doctor, referral doctors, insurance companies and/or treatment facilities.

_____ **Initials: ASSIGNMENT OF BENEFITS:** I request that payment of authorized benefits for myself and/or my dependents be paid directly to Dakota Eye Care Associates for services rendered. I agree that my medical information may be released to my insurance company as needed for payment and health care operations. I agree that a copy of my authorization may be used in place of the original.

_____ **Initials: RELEASE OF INFORMATION BY PAYORS AND NETWORKS:** I authorize Medicare, my insurance company or health organization, other payers, payer network organizations, including accountable care organizations, and their contractors, and third party administrators to share my health records and information obtained from my health care provider or any other provider, with my health care provider as needed for payment and health care operations.

_____ **Initials: HIPAA – NOTICE OF PRIVACY PRACTICES (NPP):** I acknowledge that I have been given the opportunity to review Dakota Eye Care Associates Notice of Privacy Practices and I understand the full policy is available for review at the front desk and on Dakota Eye Care Associates website. I have read and understand that my protected health information may be used for normal health care business for scheduling appointments, planning my treatment and obtaining payment from insurance companies.

_____ **Initials: HIPAA – EMAIL, TEXT AND MOBILE PHONE COMMUNICATION:** Knowing that standard email, text and mobile phone communication may not be totally secure, I still consent to communications from my doctor and staff through my standard email, texting and mobile phone devices.

_____ **Initials: CONSENT TO TREATMENT:** I request Dakota Eye Care Associates to plan and provide treatment to me and/or my dependents with my participation. I understand that I may withdraw this consent and terminate treatment at any time and for any reason.

OPTIONAL: I authorize the release of my personal health information to the person(s) named below:

_____	_____	_____	_____
Name	Relationship	Name	Relationship

Patient Signature:_____ **Date:**_____

Guardian or family member if patient unable to sign:_____

DAKOTA EYE CARE ASSOCIATES

FINANCIAL POLICY

Dakota Eye Care Associates is pleased that you have selected our practice to provide eye care for you and your family. To serve you better and avoid confusion, please read our financial policies below.

INSURANCE CLAIMS PROCESSING: Dakota Eye Care Associates will process any/all insurance claims, for which we are contracted providers, on behalf of our patients. Since it is impossible for us to keep track of every insurance plan and how it works, we expect you to know your coverage, co-pay and deductibles. Dakota Eye Care Associates will assist you with your insurance coverage and paperwork to the best of our ability if you present your current insurance card or information at the time of service.

IF YOU HAVE NO INSURANCE: If you do not have insurance that covers your exam services, payment is expected at the time of service.

CO-PAY/CO-INSURANCE: All co-pays and co-insurance required by your insurance company will be collected at the time of service. If the co-pay or co-insurance is not known at the time of service you will be billed for these fees.

REFERRALS/ PRE-CERTIFICATION/PRE-AUTHORIZATION: If an insurance referral, pre-certification or pre-authorization from another provider is required, you must present it at the time of service. If you choose to be seen without the proper referral, you agree to be responsible for all charges should they not be covered by your insurance company.

MEDICARE PATIENTS: I understand that the refraction portion of my examination is not a covered service by Medicare and, therefore, it is my responsibility to pay for this portion of the examination. A Medicare supplemental policy may pay for this service. Please refer to the Medicare ABN Form.

DISPUTES: If for any reason you dispute coverage or payments made by your insurance company, it is your responsibility to contact your insurance company and to resolve the matter based on your insurance companies arbitration or resolution process. We will provide documentation to assist you in dispute resolution.

I understand and agree that regardless of my insurance, I am ultimately responsible for the balance of my account for any services rendered. I acknowledge that I have read and understand the foregoing.

Patient Signature_____ **Date**_____

Guardian or family member if patient unable to sign_____