Guardian:

Name:

Address:

City, St: Zip:

Phone(H): W: C:

Date of Birth: Sex:

E-Mail:

Occupation:

Notify me by: ☐ Text ☐ Phone ☐ Email ☐ Mail

1. Emergency Contact Name/Phone
2. Persons authorized for medical information

Race

- ◯ American Indian or Alaska Native
- ◯ Asian
- ◯ Black or African-American
- ◯ Native Hawaiian or Other Pacific Islander
- ◯ Other Race
- ◯ Unknown/undetermined
- ◯ White

Ethnicity

◯ Hispanic or Latino ◯ Unknown
◯ Not Hispanic or Latino

Language

☐ English ☐ French ☐ Russian
☐ Spanish ☐ Japanese ☐ Other...

Tobacco Use

- ☐ 1 Current everyday smoker
- ☐ 2 Current some day smoker
- ☐ 3 Former smoker
- ☐ 4 Never smoker
- ☐ 5 Smoker, current status unknown
- ☐ 9 Unknown if ever smoked

Place & Date of Last Eye Exam:

Who may we thank for referring you to our office?

☐ Friend ☐ Insuranc ☐ Phone Book ☐ Other...

Date:

NORDBY
VISION CENTER

Nordby Vision Center
PO Box 1287
Watford City, ND 58854-1287
701-444-3221/701-444-3226 fax

Welcome:
As a new patient to our practice, we would like to offer a warm welcome and our thanks for choosing us to provide your eye health and vision care. In order for us to establish your file, and provide the most beneficial use of your time with us, the doctor has asked you to complete the following pages. The doctor needs this information in order to give you the best care possible.

OUR MISSION:
*Dedicated to enhancing quality of life by preserving the precious gift of sight.
*Respect the unique needs of each person through personalized, trustworthy, & friendly care.
*Equip patients with knowledge to make informed decisions on their visual needs.
*Provide the highest standard vision care through education, training, & technology.

Vision or Primary Insurance

Ins. Name:

Ins Number:

Relationship:

Insured:

Insured DOB: Ins. Sex: ◯ M ◯ F

Co-pay: Materials: ◯ Y ◯ N

Medical or Secondary Insurance

Ins. Name:

Ins Number:

Relationship:

Insured:

Insured DOB: Ins. Sex: ◯ M ◯ F

Co-pay: Materials: ◯ Y ◯ N

Participate in a flex spending account? ☐ Y ☐ N

What is the major purpose of this visit:

- ☐ Blur at Far
- ☐ Blur at Near
- ☐ Blur at Far & Near
- ☐ Itching
- ☐ Burning
- ☐ Redness
- ☐ Eye pain
- ☐ Eye strain
- ☐ Flashes/Floaters
- ☐ Loss of vision
- ☐ Double vision
- ☐ Sandy/Gritty
- ☐ Spots or shadows
- ☐ Diabetes eye check
- ☐ Medical eye check
- ☐ Other...

Which Eye? ☐ Right eye ☐ Left eye ☐ Both eyes

How long has it bothered you?

☐ Started today ☐ 1-2 weeks ☐ 3-6 months
☐ 1-2 days ☐ 2-4 weeks ☐ Over 6 months
☐ 3-7 days ☐ 1-3 months

Severity? ☐ Mild ☐ Moderate ☐ Severe

Getting Worse?

☐ Getting better ☐ Getting worse ☐ About the same

Eye wear History:

- ☐ Glasses
- ☐ Bifocals
- ☐ Trifocals
- ☐ No- line
- ☐ Soft Contacts
- ☐ Toric Soft
- ☐ Gas Perm
- ☐ Hard
- ☐ Monovision
- ☐ Disposable
- ☐ Overnight wear

Contact Brand: ____________________

Mark box if yes:

- ☐ Have you tried contact lenses & didn't like them?
- ☐ Not satisfied with the vision comfort of your contact lenses?
- ☐ Would prefer colored contacts?
- ☐ Do the lines and head tilting bother you with bifocals?

Lifestyle Questions:

Do you...(Check box if your answer is yes)

Computer
Reading
Student
Music
Skiing
Golf
Fishing
Tennis
Swim
Bike
Other...

Work at a computer often?
Think you might benefit from thinner lenses?
Would like to "test drive" the latest contact lenses?
Spend a lot of time outdoors?
Prefer not to wear your glasses at times?
Want info. on Laser Vision Correction surgery?
Have more than 1 pair of current Rx

Family History

- ☐ Blindness
- ☐ Cataracts
- ☐ Crossed Eyes
- ☐ Color Blind
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Macular Degen.
- ☐ Retina Disease
- ☐ Retina Detach
- ☐ Heart Disease
- ☐ High B.P.
- ☐ Thyroid
- ☐ Glaucoma
- ☐ Cancer
- ☐ None
- ☐ Other...

Past Medical History:

- ☐ Allergy
- ☐ Amblyopia
- ☐ Asthma
- ☐ Cancer
- ☐ Cataract
- ☐ Crossed Eyes
- ☐ Diabetes I
- ☐ Diabetes II
- ☐ Droopy Lid
- ☐ Ear Problem
- ☐ Eye Infection
- ☐ Eye Injury
- ☐ Eye Surgery
- ☐ Gastrointestinal
- ☐ Glaucoma
- ☐ Heart
- ☐ High B.P.
- ☐ Keratoconus
- ☐ Kidney
- ☐ Lasik
- ☐ Lazy Eye
- ☐ Macular Degen.
- ☐ Medication
- ☐ Migraine
- ☐ MS
- ☐ Psychological
- ☐ Sinus
- ☐ Thyroid
- ☐ Other...

Allergies:

☐ None ☐ Sulf ☐ Other...
☐ Penicillin ☐ Eye drops

Medical Doctor(s): ____________________

Current Medications	Amount & Frequency

I have read or had explained to me (Nordby Vision Center Ltd)'s Notice of Privacy Practice and agree to continue my care with (Nordby Vision Center Ltd) under said terms.

Remind me of my appointment by:

☐ Text ☐ Phone ☐ Email ☐ Mail

Signature____________________ Date__________

Relationship to Patient: ____________________

Printed: 11/7/14 no name