Dr. Jeffrey W. Sanger
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(308)872-2291 Fax (308)872-3122

Welcome to Our Office

Date:_____

Patient's Name _____ Male___
Last First MI Nickname Female ____

Last 4 of SSN_____ Date of Birth _____
Mailing Address _____
City_____ State _____ Zip_____
Preferred method of notification _____ Home _____Cell _____Email _____Work
Home Phone_____Cell Phone _____ Email_____
Who do we contact in an emergency_____Phone_____

If this form is being completed for an adult, please complete the following information:

Occupation_____
Employer_____ Work Phone _____
Name of Spouse_____ Spouse's Occupation_____
Spouse's Employer_____ Spouse's Work Phone_____

If this form is being completed for a dependent, please complete the following information:

If patient is a student: Grade or Year in School _____
Father's name _____Last 4 SSN_____
Address (if different from patient)_____
Occupation_____ Employer_____
Father's Work Phone_____Father's Cell Phone_____
Mother's Name_____Last 4 SSN_____
Address (if different from patient)_____
Occupation_____ Employer_____
Mother's Work Phone_____Mother's Cell Phone_____

To be compliant with Medicare and other insurance companies, we are required to ask this information.
Ethnicity_____ Race_____ Mother's Maiden Name_____
Approximate Height_____ Approximate Weight_____ Birth State_____

Full payment is due at the time service is rendered.
We accept Cash, Check, Visa, Mastercard, Discover, and Care Credit.

Medical History

Patient's Name_____Last Eye Exam_____
Primary Medical Doctor _____Last Medical Exam_____
Do you have any allergies to medications? If yes, please list and explain:
_____

Circle any of the following that you have had: Crossed eyes, lazy eye, drooping eyelid, floating spots, glaucoma, retinal disease, cataracts, eye infections, or eye injuries
Are you pregnant or nursing? ____Yes ____No
Do you wear glasses? ____Yes ____No If yes, how old is your present pair of glasses? _____
Do you currently wear sunglasses with ultraviolet protection? ____Yes ____No
Are you interested in contact lenses? ____Yes ____No
Do you wear contact lenses? ____Yes ____No Brand:_____
Contact lens solutions you use?_____
Type: ___Rigid ___Soft ___Extended wear ___Other
Are your contacts comfortable? ____Yes ____No

Social History:

Do you Drive? ____Yes ____No If yes, do you have difficulties when driving? _____
Do you use tobacco products? ___Yes ___No ___Occasionally How much/often?_____
Do you use illegal drugs? ___Yes ___No ___ Occasionally How much/often? _____
Do you drink alcohol?___Yes ___No ___ Occasionally How much/often?_____
Have you ever been exposed to or infected with: ___Gonorrhea ___Hepatitis ___HIV ___Syphilis?
_____ I would prefer to discuss my social history with the doctor.

Academic History (For children 18 and under):

Is the child achieving at expected levels at school? ____Yes ____No
When reading, does the patient display any of the following:___Poor comprehension ___Poor memory ___Eyes feel tired ___Works slowly ___Seems too hard ___Avoidance ___Eye strain ___Loses place ___Can't stay on task ___Headaches during or after reading

Please circle your current Visual or Eye Concerns:

Loss of Vision	Blurred Vision	Distorted Vision or Halos	Loss of side vision
Double Vision	Dryness	Mucous Discharge	Redness
Sandy or Gritty Feeling	Itching	Burning	Excessive Tearing or Watering
Glare or Light Sensitivity	Eye Pain/Soreness	Chronic Infection of Eye or Eyelid	Stye or Chalazion
Flashes or Floating spots	Tired Eyes	Headaches	Other

PRAIRIE
EYECARE CENTER, PC

Patient's Name _____

Personal Ocular History: Please Indicate if you have had any of the following:

Disease/Condition	Yes	No	?	Please describe any previous treatments
Glaucoma				
Cataracts				
Macular Degeneration (ARMD)				
Eye Injury				
Retinal Disease				
Other Disease				
Blindness				
Strabismus (Eye-Turning Lazy Eye)				
Amblyopia (Focusing Lazy Eye)				
Diabetes				
Dry Eyes				
Refractive (Need for Glasses)				
Other				

Family History: Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions.

Disease/Condition	Yes	No	?	Relationship to You
Glaucoma				
Cataracts				
Macular Degeneration (ARMD)				
Eye Injury				
Retinal Disease				
Other Disease				
Blindness				
Strabismus (Eye-Turning Lazy Eye)				
Amblyopia (Focusing Lazy Eye)				
Diabetes				
Cancer				
Heart Disease				
Other				

Patient's Name _____

Review of Systems: Please circle any of the following medical conditions that apply to the patient.

Constitutional	Development disability Unintended Weight loss Persistent Fever Chronic Fatigue Trauma
Cardiovascular	Heart Disease High Blood Pressure Stroke Vascular Disease
Ears/Nose/Throat/Mouth	Runny nose/Hay Fever Sinus Congestion Dry Mouth/Throat Cancer
Respiratory	Emphysema/Asthma Pneumonia Bronchitis/Cough Cancer
Gastrointestinal	Diarrhea Constipation Heartburn/Ulcer Cancer
Genitourinary	Genital/Prostrate Kidney/Bladder Ovary/Uterus/Vagina Cancer
Musculoskeletal	Muscle/Joint Pain Muscle Spasms Muscle Weakness Arthritis Muscle/Joint Swelling
Integumentary (Skin)	Eczema/Psoriasis Dermatitis Rosacea/Acne Cysts/Warts/Skin Ulcer Cancer
Neurological/ Nervous System	Seizures Multiple Sclerosis Headaches/Migraines Paralysis
Psychiatric/Mental	Depression Panic/Anxiety Disorders Mood Changes Psychoses Amnesia/Sleep Disorders
Endocrine	Diabetes Hormonal Dysfunction Cholesterol/Lipid Problems Hyperthyroidism Hypothyroidism Cancer
Hematological or Lymphatic Blood Disorders	Anemia Bleeding Problems Leukemia Cancer
Allergic/Immunologic	Allergies Rheumatoid Arthritis Lupus Autoimmune Disease
Surgical Procedure	Cataracts Tonsils Appendix

New Patient Survey

New Patient Name: _____ Date:_____

If you were referred to Prairie Eyecare Center, who referred you to our office?_____
_____
_____

What was said to you that interested you in trying out our office?

If you responded to an advertisement, which one?

What about the ad initially attracted your attention?

Once your attention was attracted to the ad, what about the ad interested you enough to read it?

If you responded to our website, how did you locate it?

What about the website interested you?

What did you hope our office would be like?