SOUTH DAKOTA BOARD OF EXAMINERS IN OPTOMETRY

PO Box 6
Langford, SD 57454
Phone: 605-493-6504
Email: sdoptboard@venturecomm.net
http://doh.sd.gov/boards./optometry/

The South Dakota Board of Examiners in Optometry

PATIENT COMPLAINT FORM

Date: __________________

Name of Complainant: ___________________________________ Date of Birth:_________________

Address: ____
Street City State Zip

Home Telephone:__________________________ Work Telephone: _____________________

Complaint against: ____

Address: ____

Telephone: ______________________________

Nature of complaint: ____
____
____
____
____
____

Date(s) on which optometric services were performed:
____
____
____

How long did the eye examination last? ____

Do you wear contact lenses? ____

If specific promises of treatment were made, please specify:
____
____
____

If specific promises were made or implied which were not fulfilled, please specify:
____
____
____

Were you informed by the examining optometrist that optometric treatment might not be successful?
____
____

Amount paid: Examination $__________ Glasses $ ___________ Contact Lenses $___________

Were there any witnesses to the optometric services performed or promises of treatment made?____________ If so please indicate:

Name: ____

Address: ____
Street City State Zip

If your complaint involves prescribed eyeglasses or contact lenses:

A. In what way(s) are the lenses unsatisfactory: _____________________________________
____
____
____

B. If the problem is vision:

1. Do you have difficulty seeing <u>distance</u>? (greater than 10 feet) ________________

2. Do you have difficulty with <u>near</u> vision? (difficulty in reading a newspaper, threading a needle, etc.)
____

C. Are the eyeglasses uncomfortable? ____

1. Does the lens “pull” your eyes or cause eye strain?____________________________

2. Do the frames fit? ____

D. Did the optometrist who examined your eyes also furnish the lenses? ______________

If the answer is no, please provide the following:

1. A copy of the optometrist’s prescription.

2. A copy of the receipt for services/products.

3. Name of person or firm providing eyeglasses/contact lenses:

   Name: ____

   Address:____
   Street City State Zip

   Telephone: ____________________________________

   a. Brand name of contact lens, if available:
   ____

   Type of contact lens; daily wear, disposable, hard, etc: _______________________

   b. Type of eyeglasses; monovision, bifocal, trifocal, etc:
   ____

4. Did the problem involve the diagnosis, treatment or cure of any disease, injury or other

   abnormal condition of the eye? ____

Did you consult another eye doctor for a second opinion? ____ If so, what date? ___________

If so, please indicate:

Name: ____

Address: ____
Street City State Zip

Telephone: _______________________________________

Nature of advice of second eye doctor: ____
____
____
____

Medical:

A. General state of health: Good __________ Fair _________ Poor __________

B. Are you aware of any medical problem which may affect your eyes? (i.e., diabetes, circulatory problems, high blood pressure, etc.)___________________________________

C. Are you taking any prescribed medication on a regular basis?________________________
____
____

Please Note:

If there should be grounds for an administrative hearing, it may be necessary for you to appear as a witness under subpoena.

Attempt to keep the communication lines open with the investigator involved in your complaint. At any stage of the complaint investigation should you resolve the problem, please notify the South Dakota Board of Examiners in Optometry so that appropriate action may be taken.

Information on your complaint will be released to the optometrists against whom you have made the complaint. It will be fully reviewed by the Board investigator to see if any South Dakota optometry laws or administrative rules have been violated. Once this procedure has taken place, you will be informed, in writing, of the disposition of your complaint.

Please complete those captions that apply to your complaint and sign the enclosed Release of Healthcare Records form and return them together to:

South Dakota Board of Examiners in Optometry
P.O. Box 6
Langford, SD 57454

____
(Signature of person making complaint)

You may use separate sheets of paper for any additional comments you may wish to make.

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ______________________ Date of Birth: ______________________

Previous Name: ______________________ Social Security #: ______________________

I request and authorize Dr. ______________________________________ to release healthcare information of the patient named above to:

Name: The South Dakota Board of Examiners in Optometry- Board Investigator

Address: PO Box 6

City: Langford State: SD Zip Code: 57454

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: ______________________

____

☐ All healthcare information

☐ Other: ____

Patient Signature: ______________________________ Date Signed: ______________________

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.