Board of Examiners in Optometry
PO Box 513
Wall, SD 57790
sdoptboard@goldenwest.net
Telephone: (605) 279-2244
Website: http://optometry.sd.gov

PATIENT COMPLAINT FORM

Date: _____

Name of Complainant: _____ Date of Birth:_____

Address: _____
Street City State Zip

Home Telephone:_____ Cell Phone: _____

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? If yes, please explain:

Amount paid: Examination $_____ Glasses $ _____ Contact Lenses $_____

Were there any witnesses to the optometric services performed or promises of treatment made?

Yes ☐ NO ☐ 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 distance? (greater than 10 feet) Yes ☐ No ☐

2. Do you have difficulty with near 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? If yes, please explain:

Did you consult another eye doctor for a second opinion? Yes ☐ No ☐

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.)Yes ☐ No ☐

D. Did you make the examining optometrist aware of these conditions? Yes ☐ No ☐

C. What prescribed medication are you taking 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
PO Box 513
Wall, SD 57790

_____
(Signature of person making complaint)

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

Board of Examiners in Optometry
PO Box 513
Wall, SD 57790
sdoptboard@goldenwest.net
Telephone: (605) 279-2244
Website: http://optometry.sd.gov

RECORD RELEASE AUTHORIZATION

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 513

City: Wall State: SD Zip Code: 57790

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.