

McDonald Optical

Patient Information and Insurance Information

Please present all Insurance: Primary and Secondary policies

Date: _____

Name: _____

Address: _____

Birth date: _____ Gender: M F

Marital Status: S M W D

Preferred Language: English Spanish

Race: American Indian or Alaska Native Asian Hispanic

Black or African American Native Hawaiian/Other White

Prefer not to answer

Ethnicity: Hispanic Not Hispanic Native Hawaiian/Other

Home Phone _____ Cell: _____

E-Mail: _____

Preferred Communication: E-mail Phone Mail

How did you find out about us? _____

Employer: _____

Work Phone: _____

Emergency contact: _____

Relationship: _____

Home Phone _____ Cell: _____

Work Phone: _____

Guarantor (must be filled out if patient is under age18)

Name: _____

Relationship: _____ Birth date: _____

Home Phone _____ Cell: _____

Address: _____

Health Information

Previous Optometrist: _____

Date of last eye exam: _____ Do you wear glasses? Y N

If so: All the time Distance Reading

Do you wear contacts? Y N Type? Soft Rigid

Hours per day: _____ Sleep in your contacts? Y N

Solution Type: _____

How often do you replace your lenses? _____

Describe any problems you have with your contacts:

Primary Physician's Name: _____

Date of last visit: _____

Are you a tobacco user? Yes No If so, how long? _____

Quit How long since quitting? _____

Medications: List any you are currently using, including eye drops:

Allergies: List allergies to medications or other substances:

Health History

Mark to indicate if you have had any of the following. Also place a mark on "F" if a blood relative has had any of the following.

Eyes

Blindness Y N F Lazy eye Y N F

Blurred vision Y N F Floaters or spots Y N F

Burning eyes Y N F Glare Y N F

Cataracts Y N F Glaucoma Y N F

Color blindness Y N F Headaches Y N F

Crossed eyes Y N F Itching eyes Y N F

Discharge Y N F Light sensitivity Y N F

Dizziness Y N F Loss of vision Y N F

Double vision Y N F Macular -

Dry eyes Y N F Degeneration Y N F

Eye infection Y N F Night vision, poor Y N F

Eye injury Y N F Red eyes Y N F

Eye surgery Y N F Seeing flashes Y N F

Eye turn Y N F Watering eyes Y N F

General Health

Allergies/ Hay fever Y N F Immunologic-
Anemia Y N F Disease Y N F

Asthma Y N F Joint pain Y N F

Bleeding problems Y N F Psychiatric Y N F

Chronic Bronchitis Y N F Rheumatoid-

Chronic cough Y N F Arthritis Y N F

Diabetes Y N F Sinus congestion Y N F

Dry throat/mouth Y N F Skin, Rash/itching Y N F

Emphysema Y N F Thyroid / glands Y N F

Gastrointestinal Y N F Vascular Disease Y N F

Heart Disease Y N F Weight loss/gain Y N F

High Blood pressure Y N F Depression Y N F

Pregnant/Nursing Y N Anxiety Y N F

If you answered yes to any of the above or have a condition not listed, please explain: _____

Please read, select options and sign:

Assignment and Release of insurance benefits: You certify that you have the provided insurance coverage and assign payment to McDonald Optical.

HIPAA Notice: I have been offered a copy and understand the Notice of Privacy Practices.

Consent for retinal photos: Downtown Location only

Yes, I want to have retinal photos taken for screening purposes which are not medically necessary. **I understand I may be charged \$30.00** for the screening fee.

Yes, I want to have retinal photos taken, **only if deemed medically necessary** by the doctor. McDonald Optical may then bill my medical insurance for these photos.

No, I do not want retinal photos taken.

Patient, Responsible Party or guardian if under 18

Signature: _____

Relationship: _____

