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: ____