McDonald Eye Associates

Patient Information Sheet

Welcome to our office. Please complete this form and return it to the receptionist. Please have all of your insurance cards ready to be copied.

Patient Name _____ Date_____
Last First Middle

Home Address_____ City_____ State_____ Zip_____

E-Mail Address_____ Patient Status: ❑ Single ❑ Married ❑ Widowed ❑ Other

Home Phone (____) _____ Work Phone (____) _____ Patient's Employer_____

Social Security #_____ Birthdate_____ Age_____

Spouse's Name_____ Spouse's Employer_____ Spouse's Work Phone (____) _____

How did you hear about us? ❑ Television ❑ Newspaper ❑ Radio ❑ Mail ❑ Doctor ❑ Work ❑ Screening ❑ Friend
❑ Nursing Home ❑ Retirement Community ❑ Internet – Which site?_____ ❑ Optometrist ❑ Other

Referred by_____

Emergency Contact_____
Last Name First Name Relationship Phone #

Last Ophthalmologist/ Optometrist seen_____ Primary Physician_____

PRIMARY INSURANCE

Insured's Name_____ Insured's Date of Birth_____ Social Security #_____

Employer/School Name_____ Patient's Relationship to Insured_____

SECONDARY INSURANCE

Insured's Name_____ Insured's Date of Birth_____ Social Security #_____

Employer/School Name_____ Patient's Relationship to Insured_____

VISION INSURANCE

Insured's Name_____ Insured's Date of Birth_____ Social Security #_____

Employer/School Name_____ Patient's Relationship to Insured_____

I understand that professional fees are due and payable at the time of treatment unless prior arrangements have been specifically made. In case my account is placed for collection, I agree to pay collection costs and expenses incurred including reasonable attorney fees.

I request that payment of authorized insurance benefits be made either to me or on my behalf to McDonald Eye Associates for any services furnished by that provider. I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine these benefits or the benefits payable for related services. I hereby authorize McDonald Eye Associates in its discretion to disclose by fax or mail any or all of the information in my medical records to any other health care provider involved in a plan of treatment for me as well as any person, corporation or agency which is or may be liable for all or part of McDonald Eye Associates charge or who may be responsible for determining the necessity, appropriateness,amount or other matter related to McDonald Eye Associates treatment or charge, including, but not limited to, insurance companies, health maintenance organizations, preferred provider organizations, workers compensation carriers, welfare funds, the Social Security Administration or its intermediaries or carriers.

I authorize release of my previous records to McDonald Eye Associates.

_____
Patient/Guardian Signature

_____
Date

_____	_____	_____
REVIEWED	REVIEWED	REVIEWED

FOR OFFICE USE ONLY

TO: _____
_____
_____

DATE: _____
PATIENT:_____
D.O.B.:_____
SSN:_____

PLEASE RELEASE MEDICAL RECORDS TO:

McDonald Eye Associates
3318 N. Hills Blvd
Fayetteville, AR 72703

(479) 521-2555 (PHONE)
(479) 521-6761 (FAX)

McDonald Eye Associates

Patient History Sheet

Please answer the following questions concerning your medical history

Name _____ DOB _____

Date of Last Eye Exam _____

The eye doctor seen was an ❑ Ophthalmologist ❑ Optometrist

Food or Drug Allergies

_____

_____

_____

_____

Current Medications

_____

_____

_____

_____

List any previous eye surgeries, injuries, or diseases you have had

Surgery, injury, or disease	Date
_____	_____
_____	_____
_____	_____
_____	_____

Do you have or have you had any of the following diseases?

	Yes	No	Please Explain
Diabetes	❑	❑	_____
Hypertension	❑	❑	_____
Heart Disease	❑	❑	_____
Kidney Disease	❑	❑	_____
Bleeding Disorder	❑	❑	_____
Other	❑	❑	_____

Family History: Does any blood relative of yours have

	Yes	No		Yes	No
Cataracts	❑	❑	Glaucoma	❑	❑
Retinal Detachment	❑	❑	Crossed Eyes	❑	❑
Blindness	❑	❑	Diabetes	❑	❑
Heart Attacks	❑	❑	Bleeding Disorder	❑	❑
Other	❑	❑			

Do you now have or have you recently had any of the following problems with your eye(s)?

	Yes	No		Yes	No
Light Sensitivity	❑	❑	Double Vision	❑	❑
Redness	❑	❑	Distorted Vision	❑	❑
Flashing Lights	❑	❑	Loss of Vision	❑	❑
Floaters	❑	❑	Decreased Far Vision	❑	❑
Itchiness	❑	❑	Decreased Near Vision	❑	❑
Scratchiness	❑	❑	Dryness	❑	❑
Trouble Focusing	❑	❑	Discharge	❑	❑
Pain	❑	❑	Glare	❑	❑
Headache	❑	❑			

McDonald Eye Associates

Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains a patient rights section describing your rights under the law. You have the right to review our notice before signing this consent. The terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. McDonald Eye Associates provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- McDonald Eye Associates has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
- McDonald Eye Associates reserves the right to change the notice of privacy policies.
- The patient has the right to restrict the uses of their information but McDonald Eye Associates does not have to agree to those restrictions.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease.
- McDonald Eye Associates may condition treatment upon the execution of this consent.

This consent was signed by:_____

Printed Name — Patient or Representative

_____

Signature — Patient or Representative

Relationship to Patient (if other than patient)_____

Date: _____

In front of: _____

Printed name — Practice Representative

McDonald Eye Associates

Patient Consent Form

Name: _____ DOB: _____

I understand that professional fees are due and payable at the time of treatment, unless prior arrangements have been specifically made. In case my account is placed for collection, I agree to pay all collection costs and expenses incurred, including reasonable attorney fees.

I request that payment of authorized insurance benefits be made either to me, or on my behalf, to McDonald Eye Associates for any services furnished by that provider. I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine these benefits or the benefits payable for related services. I hereby authorize McDonald Eye Associates, in its discretion, to disclose by fax or mail any or all of the information in my medical records to any other health care provider involved in a plan of treatment for me, as well as any person, corporation, or agency which is or may be liable for all or part of McDonald Eye Associates charge, or who may be responsible for determining the necessity, appropriateness, amount or other matter related to McDonald Eye Associates treatment or charge, including, but not limited to insurance companies, health maintenance organizations, preferred provider organizations, workers compensation carriers, welfare funds, the Social Security Administration or its intermediaries or carriers.

I authorize release of my previous records to McDonald Eye Associates.

_____

Patient/Guardian Signature

Date:_____

Release of Protected Information

I authorize the following to receive information regarding my protected health care information.

_____

Name Relationship Date

_____

Name Relationship Date

_____

Name Relationship Date