1121 S. Gilbert Road
Suite 103
Mesa, AZ 85204
Tel: 480-854-3310
Fax: 480-854-1157

MCDOUGAL EYE CENTER
DR. GUY T. MCDOUGAL AND ASSOCIATES, P.C.

7435 E. Main Street
Suite 101
Mesa, AZ 85207
Tel: 480-834-3777
Fax: 480-832-2771

Medical History/Consents/HIPAA
Patient Information

Please present Photo ID, Vision & Medical Insurance Cards and List of Current Medications

Today's Date _____

Name _____ Last Eye Exam Date _____

Address _____ Home Phone _____

Unit # _____ Cell Phone _____

City, State, Zip Code _____ Email _____

☐ Male ☐ Female Date of Birth _____ Last 4 Digits of Social Security No._____

Marital Status: ☐ Married ☐ Never Married ☐ Widowed ☐ Divorced ☐ _____

Primary Care Physician _____ Phone _____

Pharmacy Name & Cross Roads _____

Emergency Contact _____ Phone _____

Demographics Information

Preferred Language _____ ☐ Decline

Race ☐ White ☐ African American ☐ Asian ☐ Other_____ ☐ Decline

Ethnicity ☐ Hispanic ☐ Latino ☐ Other _____ ☐ Decline

Smoking Status ☐ Current ☐ Former ☐ Never ☐ Other_____ ☐ Decline

Height _____ Weight _____ ☐ Decline

Medical History

☐ Pregnant ☐ Nursing

☐ Allergies to Medications _____

☐ Diabetic ☐ High Blood Pressure

☐ Current Medical Conditions_____

☐ Medications Currently Taking (List All Vitamins, OTC Products, Prescription Medications, Contraceptives & Eye Medications)

_____

_____

_____

Family History

Please list parents, siblings, grandparents, children living or deceased.

☐ Arthritis/Lupus _____	☐ Blindness _____	☐ Cancer _____
☐ Cataracts _____	☐ Crossed Eyes _____	☐ Diabetes _____
☐ Glaucoma _____	☐ Heart Disease _____	☐ High Blood Pressure_____
☐ Mac Degeneration _____	☐ Thyroid Disease _____	☐ None

Glasses or Contacts

☐ **I wear Glasses**
- ☐ I am considering Refractive Surgery/LASIK. When?_____
- ☐ I have dry eyes. ☐ I use artificial tears.
- ☐ I use the computer ____ hours per day.
- ☐ I am interested in wearing contact lenses.

☐ **I wear Contact Lenses** Type of Contact Lenses_____ Are they comfortable? ☐ Yes ☐ No
Replace how often? ☐ Daily ☐ Two Week ☐ Monthly ☐ Other _____
☐ Experiencing problems with my contact lenses. Please explain _____

Social History

This information is strictly confidential and you may discuss it directly with the Doctor if you prefer

☐ None of the items below are applicable ☐ I will discuss directly with doctor
☐ I drive a motor vehicle
☐ I have visual difficulty when I operate my vehicle. Please explain _____
☐ I use tobacco products. Type, amount, how long?_____
☐ I drink alcohol. Type, amount, how long?_____
☐ I use illegal drugs. Type, amount, how long? _____
☐ I have been exposed or infected with one or more of the following: ☐ Gonorrhea, ☐ Hepatitis, ☐ HIV, ☐ Syphilis

Personal Ocular History

Check any of the following conditions you have experienced.

☐ Allergy Eyes ☐ Cataracts ☐ Crossed Eyes ☐ Drooping Eyelid ☐ Double Vision ☐ Eye Infections
☐ Eye Injuries ☐ Eye Surgery ☐ Headaches ☐ Glaucoma ☐ Lazy Eye ☐ Prominent Eyes
☐ Retinal Disease
☐ None ☐ Please explain if you have a condition not listed _____

Select Current and Past Conditions

☐ **I have had none of the following conditions**

Allergic/Immunologic
- ☐ Allergic

Bones/Joints/Muscles
- ☐ Rheumatoid Arthritis
- ☐ Muscle Pain

Ears, Nose, Mouth, Throat
- ☐ Allergies/Hay Fever
- ☐ Sinus Congestion
- ☐ Runny Nose
- ☐ Post-nasal Drip
- ☐ Chronic Cough
- ☐ Dry Throat/Mouth

Endocrine
- ☐ Thyroid/other Glands

Eyes
- ☐ Blurred Vision
- ☐ Burning
- ☐ Distorted Vision/Halos
- ☐ Double Vision
- ☐ Dryness
- ☐ Excess Tearing/Watering
- ☐ Floaters In Vision
- ☐ Foreign Body Sensation
- ☐ Glare/Light Sensitivity
- ☐ Itching
- ☐ Infection of Eyelid
- ☐ Light Flashes
- ☐ Loss of Side Vision
- ☐ Mucous Discharge
- ☐ Pain/Soreness
- ☐ Permanent Loss of Vision
- ☐ Redness
- ☐ Sandy/Gritty Feeling
- ☐ Stye or Chalazion

Gastrointestinal
- ☐ Diarrhea
- ☐ Constipation

Genitourinary
- ☐ Genitals/Kidney/Bladder

Integumentary (skin)
- ☐ Integumentary

Lymphatic/Hematologic
- ☐ Anemia
- ☐ Bleeding Problems

Neurological
- ☐ Headaches
- ☐ Migraines
- ☐ Seizures

Psychiatric
- ☐ Psychiatric

Respiratory
- ☐ Asthma
- ☐ Chronic Bronchitis
- ☐ Emphysema

Vascular/Cardiovascular
- ☐ Diabetes
- ☐ Heart Pain
- ☐ High Blood Pressure
- ☐ Vascular Disease
- ☐ High Cholesterol

How did you hear about us?

☐ Newspaper ☐ Mailer ☐ Banner ☐ Walk-in/Drive by ☐ Internet ☐ Insurance ☐ ZocDoc ☐ Online Reviews
☐ Referred by _____ ☐ Other _____

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Consents/HIPAA Attestation

Patient Name _____ Date of Birth _____

Retinal Photo

A Retinal photo can help with detection of Diabetes, Glaucoma, Macular Degeneration & other eye problems. Your Doctor will use it as a baseline for comparison each year. Because it is a screening, it is usually not covered by your insurance. (The cost for this screening is $39.00.)

☐ **Yes**, I would like a Retinal Photo today. ☐ **No**, I do not want a Retinal Photo today.

Pupil Dilation

Pupil dilation is recommended to ensure the best possible eye health evaluation. When dilated, you may have blurred near vision and light sensitivity for up to 6 hours. Driving is not usually impaired but may require extra caution.

☐ I would like to discuss pupil dilation with the doctor.
☐ Yes I prefer pupil dilation in order to ensure the health of my eyes.
☐ No, I understand the importance of pupil dilation but elect not to be dilated at this time.
☐ I would like to have my eyes dilated, **but not today**. I understand I can schedule a dilation to be completed **within 14 days of this eye exam** at no additional charge.

Consents and HIPAA

Would you like to have a copy of the Notice of Privacy Practices? ☐ Declined ☐ Accepted

Acknowledgement of Notice of Privacy Practices
I have been offered a copy of the Notice of Privacy Practices. I understand that Dr. Guy T. McDougal and Associates, P.C. has the right to change its Notice of Privacy Practices from time to time and that I may contact Dr. Guy T. McDougal and Associates, P.C. at any time to obtain a current copy.

Signature _____ Date_____

HIPAA Regulations Require Us to Ask With Whom May We Share Your Medical Information?
☐ Requesting Doctor's office with signed medical release by patient
☐ Spouse
☐ Other (Please List Below)

Authorization of Release of Health Information
I authorize the following individuals(s) to have accessibility to my personal health information:
Name_____ Relationship _____ Phone _____
Name_____ Relationship _____ Phone _____
Name_____ Relationship _____ Phone _____

Signature _____ Date_____

Patient's or authorized person's signature
I authorize the release of any medical or any other information necessary to process my claims. I also request payment of government benefits either to myself or to the party who accepts assignment:
Dr. Guy T. McDougal and Associates, P.C.

I authorize payment of medical benefits to Dr. Guy T. McDougal and Associates, P.C. for services rendered. I agree to be financially responsible for any balance not paid by my insurance plan(s).

I attest that I am the responsible party that filled out my Medical History on paper or electronically and/or approved the information entered on my behalf.

Please note Professional fees are non-refundable. Medicare will not pay for refractive services or routine non-medical vision care. If submitted to Medicare, you will likely be denied reimbursement. Prescription rechecks are available at no charge for 30 days from original exam by original doctor. Fees apply after 30 days or for second opinion.

Signature _____ Date_____