Patient Registration Form

Existing patients must also complete new forms every 12 months per insurance requirements

Patient Information

Patient Last Name	First Name	Middle Name	Email Address		
Address (Street or Box)		City	State	Zip	
Home Phone #	Work Phone #	Cell Phone #			
Sex (circle one) Male Female	Date of Birth	Age	Social Security #	Driver's License #	
Marital Status (circle one) Single Married Divorced Widowed			Spouse's Name (If Applicable)		
Employer Name / Occupation			Employer Address		
Primary Care Physician Name	Phone #		Referring Physician Name	Phone #	

How did you hear about the office or physician you are seeing today?

Referral TV/NBC Established Patient Newspaper Social Media/Facebook
Family/Friend Hospital Insurance Internet/Website Location/Drive By
Physician/Optometrist Referral_____ Radio (ESPN / The Ticket) Texas Rangers

Insurance & Subscriber Information

Primary Insurance Company		Effective Date	Secondary Insurance Company		Effective Date
Claims Mailing Address (Street or Box)			Claims Mailing Address (Street or Box)		
City	State	Zip	City	State	Zip
Policy ID Number	Group ID Number		Policy ID Number	Group ID Number	
Subscriber Name (policy holder)	Date of Birth		Subscriber Name (policy holder)	Date of Birth	
Subscriber Social Security #	Relationship to Patient		Subscriber Social Security #	Relationship to Patient	
Subscriber Employer	Work Phone #		Subscriber Employer	Work Phone #	
Subscriber Employer Address (Street or Box)			Subscriber Employer Address (Street or Box)		
City	State	Zip	City	State	Zip

Signature of Patient or Legal Guardian **Date**

Version 8/29/2016

TYLOCK GEORGE Eye Care

Patient Name: _____

Patient Family Health History

Blood Relative	Age If Living	Age At Death	Major Illnesses &/Or Cause of Death
Mother			
Grandmother			
Grandfather			
Father			
Grandmother			
Grandfather			
Brothers #____			
Sisters #____			
Children #____			

List any other diseases your blood relatives have:

_____

_____

Current Medications:

- List <u>all</u> of the medications that you take routinely or that are prescribed for you by a doctor. (Include vitamins, over the counter medications, eye drops, herbal medications, birth control, hormones, etc.)

Medication	Dose	How Often	Reason

If you need further space, continue with medications list on back of page →

Patient Signature _____ Date: _____

Patient Name: _____

Please check any of the following conditions that you have and/or had:

❑ Diabetes	❑ Asthma	❑ Serious Eye Infection
❑ High Blood Pressure	❑ Emphysema	❑ Serious Eye Injury
❑ Heart Disease	❑ Bronchitis	❑ Retinal Disease
❑ Arthritis	❑ Stroke	❑ Glaucoma
❑ Rheumatoid Arthritis	❑ Thyroid Disease	❑ Cataract
❑ Osteoporosis	❑ Ulcers	❑ Epilepsy
❑ Kidney Disease	❑ Colitis	❑ Prior RK Surgery
❑ Blood Clots	❑ Tuberculosis	❑ Prior Lasik / PRK Surgery
❑ High Cholesterol	❑ Autoimmune Disease	❑ Prior Cataract Surgery
❑ Prostate Disease	❑ Cancer	❑ Iritis

- Other Significant Illness _____
- Other Respiratory Problems_____
- Other Eye Surgery _____

Please check any conditions that family members have had. Indicate their relation to you:

❑ Blindness ❑ Glaucoma ❑ Crossed eyes/amblyopia (lazy eye)
❑ Cataract ❑ Retinal detachment ❑ Other serious eye disease

Are you allergic to any Medications, Latex, Iodine, Antibiotics, Foods, Pollens, Insects, Inhalants or X-Ray Contrast? ❑ Yes ❑ No
If "yes", please specify _____
_____

Do you currently weigh more than 350 pounds? (Laser Bed Weight Limit)
❑ Yes ❑ No

ARE YOU, OR HAVE YOU EVER BEEN, ON <u>FLOMAX</u> AND/OR <u>JALYN</u> for prostate disease? ❑ Yes ❑ No

Who is your current eye doctor? _____

Do you have a living will? ❑ Yes ❑ No

Do you have a durable power of attorney for health care? ❑ Yes ❑ No

Consent to Treat & Financial Responsibility

Consent to Treat

I hereby authorize employees and agents of Tylock-George Eye Care (including physicians, physician assistants and nurse practitioners and other employees and staff members) to render medical evaluations and care to the patient indicated below. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in a case of emergency.

Patient Name (please print) _____ **Date** _____

Signature of Patient or Legal Guardian _____ **Date** _____

Financial Responsibility

I hereby authorize payment of medical benefits directly to Tylock-George Eye Care and/or the attending physician for services rendered. Authorization is hereby granted to release information contained in the patient's medical record to the patient's medical insurance company (or its employees or agents) as may be necessary to process and complete the patient's medical insurance claim. I understand that this authorization may include release of information regarding communicable diseases, such as Acquired Immune Deficiency Syndrome ("AIDS") and Human Immunodeficiency Virus ("HIV"). I understand that I am financially responsible for the total charges for services rendered which may include services not covered by the patient's insurance companies. I agree that all amounts are due upon request and are payable to Tylock-George Eye Care. I further understand that should my account become delinquent, I shall pay the reasonable attorney fees or collection expenses of Tylock-George Eye Care, if any.

The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this release of information, I am responsible for payment of services in full before the services are rendered.

Patient Name (please print) _____

Signature of Patient or Legal Guardian _____ **Date** _____

TYLOCK GEORGE Eye Care

Acknowledgement of Notice of Health Information Practices

Acknowledgement of Receipt

The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and of how your medical information can be used by our staff in providing and arranging your medical care.

Tylock-George Eye Care is furnishing you with the attached notice, which provides information about how Tylock-George Eye Care and its physicians' may use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law.

By signing this form, you acknowledge that you have received a copy of Tylock-George Eye Care's Notice of Health Information Practices.

_____

Patient Name (print)

_____ _____

Signature of Patient or Legal Guardian **Date**

Effective Date of this Notice: **8/29/2016**

TYLOCK GEORGE Eye Care

Patient Preferences Regarding Communication of Patient Health Information

Preferred Method of Communication

My preferred method of communication regarding my **medical conditions** is indicated below **(check circle one):**

❑ **Home Phone** ❑ **Work Phone** ❑ **Cell Phone**

❑ **Mailed Letter** ❑ **Guardian**

If the above method of communication is by phone, please circle the appropriate request below **(circle one):**

❑ **Leave a message with detailed information**.

❑ **Leave a message with a call-back number only.**

Please note that you are responsible for any charges incurred in receiving our communications. For example, if you provide a cell phone number as a method of contact, then you are responsible for any charges imposed by your mobile carrier for receiving calls or text messages from the clinic.

Please let our office know if you have any special directions or requests regarding our communication with you. For example, please let us know if you would like for us to call you at a different phone number for a particular test result or if you do not want to be called at all.

Approved HIPAA Contacts

Keeping our patient's information private is important to us and by default we will only disclose information related to the patient's **Billing Account** and **Medical Conditions** to the **patient** or **legal guardian.**

If you would like to add additional contacts (other than the patient or legal guardian) **that Tylock-George Eye Care** is allowed to disclose this type of information to, please complete the fields below and select the appropriate checkboxes based on your approval for each person you list. In addition, please choose the person you would like Tylock-George Eye Care to list as your **Emergency Contact** in the event an emergency situation was to take place at our office.

Contact Name	Relationship to Patient	Contact Phone Number

(Please circle all that apply)

Billing Account Information **Medical Condition Information** **Emergency Contact**

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for health information from persons not listed on this form will require my specific authorization prior to the disclosure of any health information.

_____

Patient Name (please print)

_____ _____

Signature of Patient or Legal Guardian **Date**

Race, Ethnicity & Language Form

Tylock-George Eye Care is implementing a systematic method of collecting data on race, ethnicity, and communication needs directly from patients or their caregivers. The purpose of collecting this information is to ensure that all patients receive high-quality care.

We would like for you to provide us with your race and ethnic background. We will only use this information to review the treatment patients receive and make sure everyone gets the highest quality of care.

Patient Name (please print) _____

Which category best describes your race? (Please circle. You may decline to provide for any reason.)

American Indian or Alaska Native	Native Hawaiian or Other Pacific Islander
Black or African American	Multiracial
Asian (includes Pakistan or Indian origins)	Hispanic
White or Caucasian	Decline to Provide

Race Definitions: **American Indian or Alaska Native: A** person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment. **Black or African American:** A person having origins in any of the black racial groups of Africa. **White**: A person having origins in any of the original peoples of Europe, the Middle East, or North Africa. **Asian:** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. **Native Hawaiian or Other Pacific Islander:** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. **Multiracial** A person having more than one or a combination of the above origins

Do you consider yourself Hispanic/Latino?

Yes No Decline

What language do you feel most comfortable speaking with your doctor or nurse?

If needed Tylock-George Eye Care will make the best effort to provide a language interpreter service

English	Tagalog	French	Sign Language or other Auxiliary Aid or Service
Spanish	Hindi	Japanese	Other
Vietnamese	Italian		
Chinese	Korean		Decline

_____ _____

Signature of Patient or Legal Guardian **Date**

Cancellation and Missed Appointment Policy

Our goal is to provide quality individualized medical care in a timely manner. "No-shows" and late cancellations inconvenience those individuals who need access to medical care in a timely manner. We would like to remind you of our office policy regarding missed appointments. This policy enables us to better utilize available appointments for our patients in need of medical care.

No Show Policy:

A "no-show" is someone who misses an appointment without cancelling it in an adequate manner. A failure to be present at the time of a scheduled appointment will be recorded in your medical record as a "no-show." **If you are a one-day post op LASIK patient you will be considered a "No Show" if you are more than 15 minutes late for your post op appointment and you may need to reschedule your appointment.**

- **First missed appointment**: **$25 fee** will be billed to your account
- **Second missed appointment**: **$50 fee** will be billed to your account
- All Fees must be paid in full via cash, check or credit card within 30 days — this is not billable to any insurance companies.
- **Third missed appointment**: You may be discharged from our practice

Cancellation of an Appointment:

In order to be respectful of the medical needs of other patients, please be courteous and call the Tylock-George Eye Care office promptly if you are unable to show up for an appointment. This time will be reallocated to someone who is in need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Your early cancellation will give another person the possibility to have access to timely medical care.

How to Cancel Your Appointment

To cancel appointments, please call 972-258-6400. If you would like to reschedule your appointment our office staff can reschedule it for you during the call. If you are calling after hours you will need to call back during regular business hours to reschedule.

Late Cancellations:

A late cancellation is considered when a patient fails to cancel their scheduled appointment with a 24-hour advance notice.

_____ _____

Patient Signature **Date**

Tylock-George Eye Care
Patient History Information

Patient Name _____

Date _____

1) Any eye trauma/injury? **Yes** or **No**
If so, please explain _____

2) Any major eye infections? **Yes** or **No**
(Including ulcers and recurrent corneal erosion)
If so, please explain_____

3) Any prior eye surgery of any kind? **Yes** or **No**
(Including RK, PRK, LK and LASIK)
If so, please provide approximate date _____

4) Date of last eye exam_____

5) Contact lens wear? **Yes** or **No**

Soft or **Hard** Lens

Date lenses removed _____

6) Any dryness? **Never** | **Occasionally** | **Often** | **Always**

7) Night vision - please circle all that apply:

Ghosting | Glare | Halos | Starbursts

8) Age _____

9) Occupation _____

10) Any comments/concerns?

_____

_____

_____

Patient Name: _____

Tylock-George Eye Care is pleased to offer our patients the ability to receive their medical records through online electronic access from our healthcare Electronic Health Records platform. We provide this service as a convenience to communicate electronically with you under the conditions and terms outlined below.

☐ **YES**	I want Tylock-George Eye Care to communicate my information with me through a secure system that is designed to keep my information safe. ➔ You will be notified via email when there is secure information for you to review. ➔ The email will provide a link that will take you to the secure site. After clicking on the link, you will be required to log-in and provide a password to access your information. ➔ You will need to make note of the password to access any future information.
☐ **NO**	I do not want Tylock-George Eye Care to communicate my information with me through a secure electronic record system.

Please enter the e-mail address you would like to use to receive secure messages.

_____

E-mail Address (Please Print)

Electronic Communication Disclosure: Tylock-George Eye Care E-mail Guidelines

- ➔ At this time, Tylock-George Eye Care (TGEC) can only send emails to patients. Currently, TGEC is not able to accept patient emails through the messaging system.
- ➔ All e-mail you receive from TGEC is sent under the name and e-mail account of Tylock-George Eye Care (D.B.A. Tylock Eye Care).
- ➔ The patient is responsible to notify TGEC promptly of any changes to his/her e-mail address.
- ➔ All of TGEC's electronic communications to you are recorded in your medical record. Those who have access to your medical record also have access to the e-mail messages sent to you.

Confidentiality and Privacy

- ➔ If the electronic communication process described above is not used, we cannot guarantee the confidentiality of the information.
- ➔ TGEC will not share your e-mail address with anyone unauthorized to view your medical record.

Consent and Agreement

I have carefully reviewed this document and agree to fully comply with the guidelines defined herein for electronic communication from TGEC. I understand that the service will be offered at no charge and that I will be notified if and when a fee is administered for the service.

_____ _____

Patient Signature **Date**