Existing Patient Registration Form

TYLOCK GEORGE Eye Care

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) or Emergency Contact:	
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

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. I understand that by not signing this consent, the patient will not be provided medical care except in a case of emergency.

_____ _____

Signature of Patient or Legal Guardian **Date**

Patient Name: _____

Current Medications:

- List all 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 →

Are you allergic to any Medications, Latex, Iodine, Antibiotics, Foods, Pollens, Insects, Inhalants or X-Ray Contrast? ❑ **Yes** ❑ **No**

If "yes", please specify _____

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.

_____ _____

Signature of Patient or Legal Guardian **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

_____

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

ARE YOU, OR HAVE YOU EVER BEEN, ON FLOMAX AND/OR JALYN 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

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

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

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

Date of last eye exam _____

Contact lens wear? **Yes** or **No** | **Soft** or **Hard** Lens
Date lenses removed _____
Any dryness? **Never** | **Occasionally** | **Often** | **Always**

Night vision - please circle all that apply: **Ghosting | Glare | Halos | Starbursts**

Current Age _____
Occupation _____

Any comments/concerns
_____

_____