

Thomas D. Tyler M.D., Ph.D.

Patient Registration - History

Name (Last Name, First Name, Middle Initial): _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Sex: Male Female

Birth Date: _____ Social Security Number: _____

INSURANCE INFORMATION

Person Responsible for Account (Last Name, First Name, Middle Initial): _____

Relation to Patient: _____ Birth Date: _____ SSN: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Primary Insurance: _____ Policy #: _____ Group #: _____

Effective Date: _____

Secondary Insurance: _____ Policy #: _____ Group #: _____

Effective Date: _____

Tertiary Insurance: _____ Policy #: _____ Group #: _____

Effective Date: _____

Employer: _____ Occupation: _____

Business Address: _____

ADDITIONAL INFORMATION

Whom may we thank for referring you? _____

In case of Emergency, who should be notified? _____

Relation: _____ Phone: _____

I, the undersigned certify that I (or my dependent) assign directly to Dr. Thomas D. Tyler, M.D., Ph.D. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I also understand that I am responsible for verifying whether or not Thomas D. Tyler, M.D., Ph.D. is a provider on my insurance plan. In the event of default I agree to pay collection costs and reasonable attorney fees necessary to settle my account. I authorize the use of this signature on all insurance submissions. A photocopy of this document shall be as valid as the original. I understand that I will be charged a \$25.00 fee if I fail to give 24 hour notice to cancel and or fail to show up for an appointment.

Responsible Party

Relationship

Date

Symptoms Checklist

Name: _____

Date: _____

Eye Symptoms (Check all that apply.)

- | | |
|--|--|
| <input type="checkbox"/> Redness | <input type="checkbox"/> Sties, Chalazion |
| <input type="checkbox"/> Dry Eye Feeling | <input type="checkbox"/> Fluctuating Visual Acuity |
| <input type="checkbox"/> Sand or Gritty Feeling | <input type="checkbox"/> "Tired" Eyes |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Contact Lens Discomfort |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Mucous Discharge |
| <input type="checkbox"/> Foreign Body Sensation | <input type="checkbox"/> Poor Night Vision |
| <input type="checkbox"/> Constant Tearing | <input type="checkbox"/> Rings or Halos Around Light |
| <input type="checkbox"/> Occasional Tearing | <input type="checkbox"/> Glare From Light |
| <input type="checkbox"/> Watery Eyes | <input type="checkbox"/> Eye Pain or Soreness |
| <input type="checkbox"/> Light Sensitivity | <input type="checkbox"/> Poor Color Vision |
| <input type="checkbox"/> Hazy or Blurry Vision | <input type="checkbox"/> Double Vision |
| <input type="checkbox"/> Seeing in Poor or Dim Light | |

Do you have difficulty, even with glasses, with the following activities? (Check all that apply.)

- Reading small print, such as labels on medicine bottles
- Reading a newspaper or book
- Reading a large-print book
- Recognizing people when they are close to you
- Seeing steps, stairs, or curbs
- Reading traffic signs, street signs, or store signs
- Doing fine handwork like sewing, knitting, or carpentry
- Writing checks or filling out forms
- Playing games such as bingo, dominos, or card games
- Taking part in sports like bowling, handball, tennis, or golf
- Cooking
- Watching Television

Driving (Check all that apply.)

- Have you ever driven a car?
- Are you having difficulty driving during the day due to your vision?
- Are you having difficulty driving at night due to your vision?

PROVIDER NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

Uses and Disclosures: We use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Continuity of care is part of treatment and your records may be shared by paper mail, electronic mail, fax, or other methods. We may use or disclose identifiable health information about you without your authorization in several situations, but beyond those situations, we will ask for your written authorization before using or disclosing any identifiable health information about you.

Your rights: In most cases, you have the right to look at or get a copy of health information about you. If you request copies, we will charge you only normal photocopy fees. You also have the right to receive a list of certain types of disclosures of your information that we made. If you believe that information in your record is incorrect, you have the right to request that we correct the existing information.

Our legal duty: We are required by law to protect the privacy of your information, provide this notice about our information practices, follow the information practices that are described in this notice, and seek your acknowledgement of receipt of this notice. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area. You can request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

Complaints: If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

If you have any questions or complaints, please contact:

Thomas D. Tyler M.D., Ph.D.
1140 Laurel Street, Suite A
San Carlos, CA 94070
650 551-1103



Acknowledgement of receipt of Notice of Privacy Practices:

Please sign your name and print your name and date on this acknowledgement form. Then detach the form from the Notice along the dotted line and return your signed acknowledgement to the receptionist or to the address above.

Signature: _____

Printed Name: _____ Date: _____