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

Thomas D. Tyler, M.D., Ph.D.
Tel: 650-551-1103

1140 Laurel Street, Suite A
San Carlos, CA 94070-5009

Name: _____ Birth Date: _____ Date: _____

Primary Care Physician: _____

Current Medications

1. _____
2. _____
3. _____
4. _____

Allergies

1. _____
2. _____
3. _____
4. _____

Circle any that apply below or » ***Fill in explanation***

Eyes / Glaucoma, cataract, lazy eye, retinal problems, burning, itching, dry, blurry, double vision ☐ Yes ☐ No _____

Constitutional
Fever, weight loss, other ☐ Yes ☐ No _____

Ear/nose/mouth/throat
Hearing loss, sinus problems, sore throat ☐ Yes ☐ No _____

Cardiovascular
Heart problems, hypertension, irregular heart beat ☐ Yes ☐ No _____

Respiratory
Asthma, shortness of breath, wheezing, coughing ☐ Yes ☐ No _____

Gastrointestinal
Heartburn, abdominal pain, diarrhea, vomiting, ulcer ☐ Yes ☐ No _____

Integumentary (skin)
Rashes ☐ Yes ☐ No _____

Musculoskeletal
Muscle aches, joint pain, swollen ankles ☐ Yes ☐ No _____

Neurological
Numbness, weakness, headaches, paralysis, stroke ☐ Yes ☐ No _____

Hematologic / Lymphatic
Blood disorders, leukemia ☐ Yes ☐ No _____

Endocrine
Diabetes, thyroid disorder ☐ Yes ☐ No _____

Psychiatric
Depression, anxiety ☐ Yes ☐ No _____

Do you wear contact lenses? ☐ Yes ☐ No If so, what type? _____

Family and Social History

Do any medical or eye diseases run in your family? ☐ Yes ☐ No If so, note relationship next to disease below.

Glaucoma _____ High blood pressure _____

Diabetes _____ Macular degeneration _____

Do you smoke? ☐ Yes ☐ No Do you drink alcohol? ☐ Yes ☐ No

If yes, how much? _____ If yes, how much? _____

Reviewed by physician: _____ Date: _____

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Symptoms Checklist

Name: _____ Date: _____

Eye Symptoms (Check all that apply.)

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

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?

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Patient's Name: _____

ADVANCE BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving these health care items or services. We expect that your Insurance Carrier may not pay for the item(s) or service(s) that are described below. Your insurance carrier may not pay for all of your health care costs. Your insurance carrier may pay only for covered items and services when your insurance carrier rules are met. The fact that your insurance carrier may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, your insurance carrier may **not pay for** —

Items or Services: **CPT: 92015 REFRACTION**
Because: Your Insurance Carrier May Not Pay For Non-Emergency or Routine Examinations.

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully.**

- Ask us to explain, if you don't understand why your insurance carrier probably won't pay.
- Ask us how much these items or services will cost you (Estimated Cost: $52.00), in case you have to pay for them yourself or through other insurance.

PLEASE CHOOSE **ONE** OPTION. CHECK ONE BOX. SIGN & DATE YOUR CHOICE.

☐ Option 1. **YES. I want to receive these items or services.**

I understand that my insurance carrier will not decide whether to pay unless **I receive these items** or services. Please submit my claim to my insurance carrier. I understand that you may bill me for **items** or services and that I may have to pay the bill while my insurance carrier is making its decision. If my insurance carrier does pay, you will refund to me any payments **I** made to you that are due to me. If my insurance carrier denies payment, **I** agree to be personally and fully responsible for payment. That is, **I** will pay personally, either out of pocket or through any other insurance that **I** have. **I** understand **I can appeal my insurance carrier's decision.**

☐ Option 1. **NO. I have decided not to receive these items or services.**

I will not receive these items or services. I understand that you will not be able to submit a claim to your insurance carrier and that I will not be able to appeal your opinion that your insurance carrier won't pay.

_____ _____

Signature of patient or person acting on patient's behalf Date

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to My insurance carrier, your health information on this form may be shared with my insurance carrier. Your health information which my insurance carrier sees will be kept confidential by my insurance carrier.

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: ______________