REGISTRATION FORM

TODAY'S DATE_____

PLEASE PRINT

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

Address: _____
(Street) **(City)** **(State)** **(Zip Code)**

Home Phone: (____) _____ **Cell:** (____) _____ **Email Address:** _____

□ **Single** □ **Married** □ **Widowed** □ **Divorced** **Sex:** □ **Male** □ **Female**

DOB: _____ **Age:** _____ **SSN:** _____

Occupation: _____ **Office Phone:** (____) _____

Employer: _____ **Address:** _____

Name of Spouse/Parent or Guardian: _____ **DOB:** _____

Address: _____ **Residence Phone:** (____) _____

Employer: _____ **Business Phone:** (____) _____

How did you hear about us? □ **Doctor Referral** □ **Google**
□ **Patient** □ **Social Media**
□ **Magazine** □ **Commercial**
□ **TOC Med Spa** □ **Health Fair**
□ **Website** □ **Other:** _____

Appointment confirmation preference: □ **Text Message** □ **Email** □ **Do not confirm**

Ethnic Background: □ **Hispanic** □ **Not Hispanic**

Race: □ **Indian/Eskimo/Aleut** □ **Asian/Pacific** □ **Islander** □ **Black** □ **Caucasian** □ **Other:** _____

Primary Medical Insurance: _____
(Name) **(Policy Number)** **(Group Number)**

Policy Holder's Name: _____ **SSN:** _____ **DOB:** _____

Secondary Medical Insurance: _____
(Name) **(Policy Number)** **(Group Number)**

Policy Holder's Name: _____ **SSN:** _____ **DOB:** _____

In Case of Emergency, Please Notify: _____
(Name) **(Relationship)**

Work Phone: (____)_____ **Home Phone:** (____)_____

I understand that my physician may release any medical record information of mine or my dependent to evaluate, treat and submit claims to my insurance company. I understand and agree that payment of medical benefits due to me be paid directly to Texas Oculoplastic Consultants. I understand that I am responsible for payment of all services rendered on my behalf or my dependent not covered by my insurance. I agree that payment is due at the time of service unless other arrangements have been made and agreed upon. If payment is not received by agreed dates, I will reimburse TOC Eye and Face the fees of any collection agency, which may be based on a percentage at a maximum of 30% of the debt, and all costs, and expenses, including reasonable attorneys' fees, we incur in such collection efforts. If required, I also understand that a check of my credit history may be made. This consent will remain in effect until revoked by me in writing.

PAYMENT IS EXPECTED AT THE TIME THAT OFFICE SERVICES ARE RENDERED. THANK YOU.

Signature: _____ **Date** _____

I acknowledge that the Notice of Privacy Practices has been made available to me in the lobby of Texas Oculoplastic Consultants.

Signature: _____ **Date** _____

(Revised 06/2020)

TOC MEDICAL HISTORY FORM

Name _____ DOB_____Age_____Height_____Weight_____Date_____

Reason for Visit: _____

MEDICAL ALLERGIES OR SENSITIVITIES

- Do you have any medication or food allergies/sensitivities?
  ☐ No ☐ Yes If so, please list: _____
- Have you ever had any reaction to latex/rubber? ☐ No ☐ Yes Adhesive ☐ No ☐ Yes

If yes to either, please explain: _____

Can you stand and bear your own weight? ☐ Yes
☐ No Please indicate: ☐ Inability to stand ☐ Walker ☐ Wheelchair

MEDICATION ☐ None

Do you take a daily aspirin? ☐ No ☐ Yes Is it preventative ☐ No ☐ Yes

Please list all over the counter and prescribed medications you take:

1._____ 4._____ 7._____
2._____ 5._____ 8._____
3._____ 6._____ 9._____

OCULAR HISTORY: please check box if you currently have or have ever had these conditions

☐ Anophthalmia (lost an eye) ☐ Right ☐ Left
☐ Amblyopia (lazy eye) ☐ Right ☐ Left
☐ ARMD (macular degeneration) ☐ Right ☐ Left
☐ Cataracts ☐ Right ☐ Left
☐ Glaucoma ☐ Right ☐ Left
☐ Graves' thyroid eye disease ☐ Right ☐ Left
☐ Retinal detachment ☐ Right ☐ Left
☐ Strabismus (crossed eyes) ☐ Right ☐ Left
☐ None

STAFF USE ONLY:

BP: _____

Pulse: _____

BMI: _____

MEDICAL HISTORY: please check box if you currently have or have ever had these conditions

☐ Arthritis
☐ Asthma
☐ Thyroid disease
☐ Cancer Type: _____
Treatment: ☐ Chemo ☐ Radiation ☐ Surgery
☐ Angina (chest pain)
☐ Irregular heart rhythm or rapid heartbeat (atrial fib, SVT)
☐ High blood pressure (hypertension)
☐ Heart disease (coronary artery disease or heart attack)
☐ Congestive heart failure
☐ HIV
☐ Bleeding disorders
☐ Other _____
☐ None
☐ Liver disease (hepatitis) Type _____
☐ Stomach ulcers
☐ Gastroesophageal reflux disease (GERD)
☐ Diabetes
☐ Kidney disease
☐ Tuberculosis
☐ Lung disease (emphysema / COPD)
☐ Requires continuous oxygen
☐ Obstructive sleep apnea ☐ Requires CPAP
☐ Stroke or other Brain injury Date _____
☐ Seizures
☐ Anesthesia Complications

☐ Trouble breathing through nose? ☐ History of sinus issues?

- Would you like to meet with one of our providers to further discuss? ☐ Yes ☐ No

☐ **FEMALES**: date of last menstrual period? _____

FAMILY HISTORY:

- ☐ Anesthesia complications
- ☐ Bleeding disorders
- ☐ Diabetes
- ☐ Heart disease
- ☐ High blood pressure (hypertension)
- ☐ Thyroid disease

SURGICAL HISTORY: please included ALL previous surgeries, even if not listed

- ☐ Cataract surgery ☐ Right ☐ Left
- ☐ Glaucoma surgery ☐ Right ☐ Left
- ☐ Cardiac pacemaker/defibrillator
  When was your last check? _____
- ☐ Cardiac stent placement When?_____
- ☐ Coronary artery bypass (CABG) When?_____
- ☐ LASIK refractive surgery
- ☐ Eyelid surgery
- ☐ Face lift
- ☐ Nose surgery (rhinoplasty)
- ☐ Other _____
- ☐ None

SOCIAL HISTORY

- Have you ever used tobacco or products containing nicotine? ☐ No ☐ Yes
- Type of Tobacco Used: ☐ Cigarette ☐ Cigar ☐ Pipe ☐ Chewing ☐ Smokeless ☐ Vape ☐ Other _____
  Usage:☐ Daily Per day usage: _____ ☐ Occasional Usage: _____
  ☐ Formerly When did you quit? _____

- Alcohol use? ☐ No ☐ Yes Frequency ☐ Daily ☐ Weekly ☐ Rarely

- Recreational drug use? ☐ No ☐ Yes Type _____ ☐ Formerly When did you quit? _____

CURRENT PHYSICIANS

Primary Care Physician

Name: _____ Address: _____

Telephone: (____)_____ City/State: _____

Cardiologist (please indicate if not applicable)

Name: _____ Address: _____

Telephone: (____)_____ City/State: _____

Physician Who Referred You (if not your Primary Care Physician)

Name: _____ Address: _____

Telephone: (____)_____ City/State: _____

Preferred Pharmacy (location you would like us to send any medications prescribed)

Name: _____ Address: _____

Telephone: (____)_____ City/State: _____

X_____ _____

Patient Signature ***Date***

HIPAA Release of Information
AUTHORIZATION FORM

This optional Authorization grants permission to the Designated party (ex: spouse, parent, etc.) named below to:

- **Make or confirm appointments**
- **Have access to x-ray, laboratory, or test findings**
- **Have access to telephone communication and answering machine messages as well as other common means of communication, including but not limited to text messages containing personal health information.**
- **Pick up sample medications**
- **Be made aware of my diagnosis, prognosis, and treatment plans**
- **Have access to my financial health information and medical records.**

I hereby authorize TOC Eye and Face to use and disclose my individually identifiable health information as described above. I understand that this authorization is voluntary. I understand that once this information is released to the Designated Party(ies) named below, the released information may no longer be protected by federal privacy regulations.

Patient Name:_____ **Date of Birth:_____**

Mobile Phone: _____

Designated party:_____ Relationship to patient:_____

Address_____

Phone:_____ Email: _____

Designated party:_____ Relationship to patient:_____

Address:_____

Phone:_____ Email: _____

The patient or patient's representative must read and initial the following statements:

1. I understand that this authorization will: ***(Must check one)***
   ( ) expire 1 year from the date signed by the patient or patient's representative; or
   ( ) be effective for the lifetime of the patient unless revoked

2. I understand that I may revoke this authorization at any time by notifying in writing; however, if I do revoke the authorization, it will not have any effect on any actions taken by ***Texas Oculoplastic Consultants*** prior to their receipt of the revocation.

3. I understand that my treatment cannot be conditioned on whether I sign this authorization.

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

_____ _____
Signature of patient or patient's representative Date
(*Form **MUST** be completed before signing or will not be valid)*

Printed Name of Patient's Representative: _____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

TOC
EYE AND FACE

CONSENT TO PHOTOGRAPHY

I hereby authorize photographs to be taken for medical purposes.
I agree to the use of the negative, prints, copies or reproductions for insurance documentation, teaching and for monitoring my condition.

_____ _____
Signature of patient Date

_____
Printed Name

I am open to TOC Eye and Face using my before and after photographs for marketing. If checked, a TOC staff member will contact you for formal written permission before posting or publishing.

☐ Yes ☐ No

If the patient is a minor or unable to sign, complete the following:

Father_____

Mother_____

Guardian or other person/relationship_____

Request for Amendment of Protected Health Information

You have the right to request an amendment of your protected health information maintained by Texas Oculoplastic Consultants if you believe the information is not accurate or completed. You must submit your request through our patient portal. If the patient is a minor child, the legally authorized representative must request the amendment through the patient portal.

If your request for amendment is approved, the original documentation will not be changed or deleted. Your amendment will be appended or l inked to the information that is being amended.