



RESTORATION EYECARE

TIMOTHY MCGARITY, M.D.

Welcome to Restoration Eye Care! Our goal is to provide you with compassionate, timely and accurate care.

Please read and fill out all the enclosed forms, including your signature on the "patient registration" and "medical release information" forms, and bring these completed forms with you on the day of your appointment. Please let us know if we may assist you in completing these forms. We strive to keep your paperwork to a minimum. Allow 15 to 30 minutes to complete the paperwork entirely.

You may be dilated at this appointment. Most patients do not have a problem with dilation and can drive themselves home; however, if you feel uncomfortable with dilation, you may consider bringing a driver. We will also have disposable sunglasses available. Please bring your glasses and remember you must be out of your contacts two weeks for soft daily wear lenses or three weeks for gas permeable lenses. If you are just scheduled for a screening, you only need to be out of your contact lenses for 24 hours. If you cannot comply, please consider rescheduling your appointment.

If you would like additional information about LASIK before your appointment, look us up on the web, www.RestorationEyeCare.com, or check us out on [Facebook](#). If you are unable to keep this appointment, please call our office during regular office hours so that we will be able to schedule another patient. We look forward to seeing you. Our office hours are Monday - Thursday 8:00 AM to 4:00 PM. Effective May 1, 2012 if your appointment is not cancelled within 24 business hours your account will be charged a **\$25 No Show fee**. Thank you.

We look forward to seeing you in our clinic, located at:

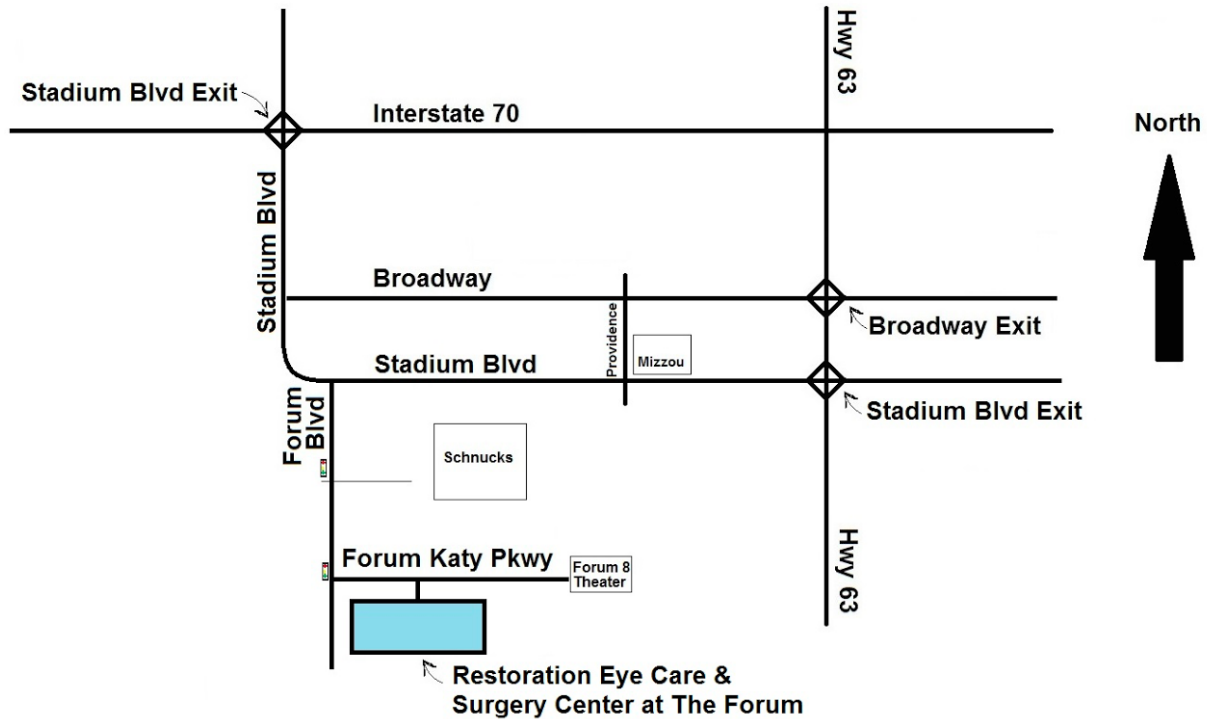
Restoration Eye Care
Lasik Center at The Forum
1410 Forum Katy Parkway, Suite 101
Columbia, MO 65203

1410 Forum Katy Parkway, Columbia, MO 65203-3842
Tel: (573) 441-7070 Fax: (573) 441-2288 www.restorationeyecare.com



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The Forum Medical Park
Restoration Eye Care, Suite 100
Surgery Center at The Forum, Suite 102
1410 Forum Katy Parkway
Columbia, MO 65203

From Hwy 63	From I-70
<p>Stadium Exit & Turn West Stay on Stadium for 3.6 miles (7-10 minutes) Turn South (Left) to Forum Blvd Go to 2nd Stoplight & Turn Left Take next right to parking</p>	<p>Stadium Exit & Turn South Stay on Stadium for 2.7 miles (6-9 minutes) Turn South (Right) to Forum Blvd Go to 2nd Stoplight & Turn Left Take next right to parking</p>

1410 Forum Katy Parkway, Columbia, MO 65203-3842
Tel: (573) 441-7070 Fax: (573) 441-2288 www.restorationeyecare.com



Patient Registration

Patient Name: _____

SSN: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ ZIP: _____

Primary Phone Number: _____ Home Cell Other

Alternate Phone Number: _____ Home Cell Other

E-Mail: _____

Marital Status: Single Married Partner Divorced Widowed

Employer: _____ Work Number: _____

Work Address: _____

Spouse or nearest relative: _____ Relationship to patient: _____

Primary Phone Number: _____ Home Cell Work

Alternate Phone Number: _____ Home Cell Work

Referring Physician: _____

Family Physician: _____

Pharmacy Name/Location: _____

Patient's Medicare, Medigap and Supplemental Lifetime Authorization

I request that payment of authorized Medicare benefits be made on my behalf to Restoration Eye Care for any services furnished to me by my provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I request payment of authorized Medigap benefits be made to this provider and also authorize any holder of medical information about me to release to the above named Medigap insurer any information needed to determine benefits payable for services from this provider.

AUTHORIZATION: I hereby authorize any insurance benefits to be paid directly to RESTORATION EYE CARE and acknowledge that I am financially responsible for any unpaid balance. If my account is sent to a collection agency for non-payment, I will be responsible for any collection fee.

AUTHORIZATION: I authorize RESTORATION EYE CARE to release necessary medical information to insurance carriers and to referring physicians concerning my health care and treatments.

I have read and understand the Health Information Practices of Restoration Eye Care.

Patient's Signature

Date



AUTHORIZATION TO RECEIVE/RELEASE HEALTH INFORMATION

HIPAA Compliance Privacy Laws of the Federal Government require that we ask you to review and answer the following questions listed below.

Patient's Name: _____

May we leave messages/detailed medical information on voicemail or text message at either of these phone numbers?

Yes No **Home Phone:** _____

Yes No **Cell Phone:** _____

May we leave messages/detailed medical information by email?

Yes No **Email address:** _____

May we contact you at your place of employment? Yes No

If so, may we leave a message? Yes No

If yes: **Work Phone:** _____ **Extension:** _____

Do you have any particular person or family members that you authorize to receive and discuss information regarding your personal health information (general information, surgical and billing)?

Yes No

If yes, please provide:

Name: _____ **Relationship:** _____

Phone Number: _____ **Alternate Number:** _____

Do you have a person who is your Power of Attorney for medical purposes? Yes No

If yes, please provide:

Name: _____ **Relationship:** _____

Phone Number: _____ **Alternate Number:** _____

I hereby authorize Timothy D. McGarity, M.D. P.C. d/b/a Restoration Eye Care, Mid-Missouri Surgery Center, LLC, d/b/a Surgery Center at The Forum and Anesthesia Services of Mid-Missouri, LLC to obtain or release any and all pertinent information regarding my medical care, as needed, to assist in my ongoing treatment to or from other health care providers, laboratories, radiology facilities or other institutions. **This authorization remains in effect until revoked.**

I have reviewed the aforementioned information and provide my consent regarding any and all the issues as stated above. I have reviewed this Notice of HIPAA Privacy Policy. A copy of this policy will be provided to me upon request.

Patient Signature: _____ **Date:** _____



Medical History Form

Bring this completed form to your appointment, or arrive early to your appointment so that we may assist you in filling out this form.

Current Eye or Eye related problems or complaints (check all that apply)

- Cataract, Decreased Vision, Discharge, Glare, Itching/Burning, Redness, Dryness, Halos, Other or explain any concerns:

Past Eye Surgery Date Explanation N/A

- Check here if No Past Eye Surgeries, Cataract Surgery, Glaucoma Surgery, LASIK/PRK/RK, Other Eye Surgery

Prior Eye Problems (please mark all that apply)

- Check here if No Past Eye Problems/History, Astigmatism, Presbyopia, Color Blindness, Double Vision, Eye or Eyelid Cancer, Facial Rosacea, Eye Shingles, Severe Eye Injury, Farsightedness, Tearing/Watering Constantly, Pupil Problems, Cataract, Cloudiness After Cataract Surgery, Nearsightedness, Lazy Eye, Crossed or Turned Eyes, Droopy Eyelid, Eye Allergies, Eye Herpes, Keratoconus, Eye Bone Fracture, Cornea Infection, Dry Eye Syndrome, Iritis/Uveitis, Optic Neuropathy, Myasthenia Gravis

Patient Name:



(Continued)

- Dislocated Lens (Ectopia Lentis)
- Retinal Detachment
- Retinal Tear without Detachment
- Diabetic Retinopathy
- Epiretinal Membrane (ERM)
- Floaters (Posterior Vitreous Detachment-PVD)
- High Eye Pressure (Ocular Hypertension)
- Idiopathic Intracranial Hypertension
- Sudden or Intermittent Loss of Vision
- Blocked Retinal Artery (CRAO, BRAO, Giant Cell Arteritis)
- Intraocular Foreign Body
- Blind Eye
- Macular Degeneration
- Blocked Retinal Vein (CRVO, BRVO)
- Retinal Swelling (Cystoid Macular Edema)
- Glaucoma
- Optic Neuritis (from Multiple Sclerosis)
- Thyroid Eye Disease (Graves Disease)
- Pituitary Tumor (Pituitary Adenoma)

Medical History (please provide explanation of any checked in the space below)

Check here if No Past Medical Problems/History

- | | | |
|---|---|--|
| <input type="checkbox"/> Anesthetic Complications | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Brain Tumor |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Emphysema (COPD) |
| <input type="checkbox"/> Sleep Apnea (or machine) | <input type="checkbox"/> Asthma | <input type="checkbox"/> Pneumonia in last month |
| <input type="checkbox"/> Oxygen Requirement at Home | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Congestive Heart Failure (CHF) |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Irregular Heart Rhythm | <input type="checkbox"/> Heart Stents in last 6 months |
| <input type="checkbox"/> Heart Valve Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Pacemaker/Defibrillator Implant |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Migraine | <input type="checkbox"/> AIDS/HIV |
| <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Dementia |

Explanation- _____

Other Surgical History? Date? (Heart Surgery, 2003 for example)

Check here if No Past Surgeries or Procedures

Patient Name: _____



Social, Family and Occupational History

Do you smoke? Yes, often Yes, occasionally No, but I used to No, never smoked

What kind of tobacco? Cigarette Cigar Pipe

Drink Alcohol? Yes, often Yes, occasionally No, but I used to No, never drank

What type of alcohol? Beer Wine Liquor

Illicit drugs? Yes, often Yes, occasionally No, but I used to No, never

Immediate Family History (Please check all that apply). Please note relation to yourself using F-Father, M-Mother, S-Sister, B-Brother (example: Diabetes-F or Glaucoma-S/B)

- Check here if **No Known Family History**
- Cataracts _____
- Blindness _____
- Crossed/Lazy Eye _____
- Corneal Disease _____
- Other Eye Problems _____
- Other Disease _____
- Arthritis _____
- Diabetes _____
- Macular Degeneration _____
- HIV _____
- Stroke _____
- Glaucoma _____
- Heart Disease _____
- Rheumatoid Arthritis _____
- Lupus _____

What hobbies do you enjoy?

What is/was your occupation?

Patient Name: _____



Medication & Allergy Reconciliation You may substitute this page by providing us with a neatly printed list of your allergies & medications. **Patient Name:** _____

Allergies (example: **Allergy:** Penicillin. **Reaction:** Rash or stopped breathing) Check if **No Known Allergies**

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

Medication Taken – Include all OTC supplements and vitamins Check only if **Not taking Any Medications**

Medication name and reason taken	How much? (Dosage)	How do you take it?	How often? (Frequency)	When was your last dose?	Physician Circle
(example) Albuterol for Asthma	2 puffs	Inhale	2 times	this morning	
1.					Cont. DC New RX
2.					Cont. DC New RX
3.					Cont. DC New RX
4.					Cont. DC New RX
5.					Cont. DC New RX
6.					Cont. DC New RX
7.					Cont. DC New RX
8.					Cont. DC New RX
9.					Cont. DC New RX
10.					Cont. DC New RX
11.					Cont. DC New RX
12.					Cont. DC New RX



Review of Body Systems – Please check correct box in each category for any current problems or symptoms

<p><u>Cardiovascular</u> <input type="checkbox"/> Chest Pain <input type="checkbox"/> Irregular Heartbeat <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Heart Attack <input type="checkbox"/> Heart Valve Disease <input type="checkbox"/> N/A</p>	<p><u>General</u> <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Night Sweats <input type="checkbox"/> Weakness <input type="checkbox"/> Weight Loss <input type="checkbox"/> N/A</p>	<p><u>Allergy</u> <input type="checkbox"/> Chronic Runny Nose <input type="checkbox"/> Hives <input type="checkbox"/> Itching <input type="checkbox"/> N/A</p>	<p><u>Genitourinary</u> <input type="checkbox"/> Discharge <input type="checkbox"/> Sores <input type="checkbox"/> Painful <input type="checkbox"/> Urgency <input type="checkbox"/> N/A</p>
<p><u>Blood Pressure Control</u> <input type="checkbox"/> Good BP Control <input type="checkbox"/> Borderline BP Control <input type="checkbox"/> Poor BP Control <input type="checkbox"/> Unknown BP Control <input type="checkbox"/> N/A</p>	<p><u>Ears/Nose/Throat</u> <input type="checkbox"/> Dizziness <input type="checkbox"/> Ringing in Ears <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Hoarseness <input type="checkbox"/> Sore Throat <input type="checkbox"/> N/A</p>	<p><u>Hematologic</u> <input type="checkbox"/> Bleeding <input type="checkbox"/> Bruising <input type="checkbox"/> Tender Nodes <input type="checkbox"/> Clotting <input type="checkbox"/> Anemia <input type="checkbox"/> N/A</p>	<p><u>Metabolic</u> <input type="checkbox"/> Cold Intolerance <input type="checkbox"/> Excess Hunger <input type="checkbox"/> Heat Intolerance <input type="checkbox"/> Excessive Thirst <input type="checkbox"/> Frequent Urination <input type="checkbox"/> N/A</p>
<p><u>Musculoskeletal</u> <input type="checkbox"/> Back Pain <input type="checkbox"/> Joint Pain <input type="checkbox"/> Muscle Aches <input type="checkbox"/> Stiffness <input type="checkbox"/> Swelling <input type="checkbox"/> N/A</p>	<p><u>Diabetes Control</u> <input type="checkbox"/> Good Control <input type="checkbox"/> Borderline Control <input type="checkbox"/> Poor Control <input type="checkbox"/> Unknown Control <input type="checkbox"/> N/A</p>	<p><u>Neurological</u> <input type="checkbox"/> Balance Problems <input type="checkbox"/> Headache <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Stroke/Seizure <input type="checkbox"/> N/A</p>	<p><u>Psychiatric</u> <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Insomnia <input type="checkbox"/> Irritability <input type="checkbox"/> Nervousness <input type="checkbox"/> N/A</p>
<p><u>Respiratory</u> <input type="checkbox"/> Cough <input type="checkbox"/> COPD/Emphysema <input type="checkbox"/> Trouble Breathing <input type="checkbox"/> Wheezing <input type="checkbox"/> Asthma <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> N/A</p>	<p><u>Skin</u> <input type="checkbox"/> Hair Loss <input type="checkbox"/> Rash <input type="checkbox"/> Skin Lesions <input type="checkbox"/> N/A</p>	<p><u>Pregnancy (are you pregnant?)</u> <input type="checkbox"/> First Trimester <input type="checkbox"/> Second Trimester <input type="checkbox"/> Third Trimester <input type="checkbox"/> N/A</p>	<p><u>Endocrine</u> <input type="checkbox"/> Thyroid <input type="checkbox"/> Hypoglycemic <input type="checkbox"/> Hyperglycemic <input type="checkbox"/> N/A</p>

<p><u>Gastrointestinal</u> <input type="checkbox"/> Liver Disease <input type="checkbox"/> GERD (acid reflux) <input type="checkbox"/> N/A</p>	<p>This section is used by the physician for updating purposes only: For vital signs, see <i>Physician's Order & Authorization Note</i> H & P updated date and time of Physician's signature</p> <p>_____, M.D. Date</p>
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Patient Name: _____