RESTORATIONEYECARE
TIMOTHY McGARITY, M.D.

Welcome to Restoration Eye Care

Thank you for choosing us. 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. Completed paperwork will speed up your check in process. Also, bring all of your insurance cards, a photo ID, and a list of any medications that you are taking. We accept most insurance plans and Medicare.

If you have a co-payment it will be collected at the time of service (this does not apply to those who have Medicare and/or supplemental insurance). We accept most forms of payment.

If your health insurance company requires a referral to visit a specialist, then please verify in advance that we have received a referral from your Primary Care Physician, not your eye doctor. We can not see you if you needed a referral that was not sent to us. Please let us know if you need assistance with a referral before the day of your appointment.

New patients will be dilated, so please bring a driver if necessary. If possible, please avoid wearing contact lenses on the day of your appointment. Expect to be with us for at least one hour. For more information we encourage you to visit our website www.RestorationEyeCare.com or give us a call. If you are unable to keep this appointment, please call our office during regular office hours, Monday through Thursday between 8:00 A.M. and 4:00 P.M or Friday between 8:00 A.M. and Noon. If your appointment is not cancelled within 24 business hours, then your account will be charged a **$25 No Show fee**. No Shows are costly to everyone, and we want to fill each appointment slot for patients who need assistance.

We look forward to seeing you in our office at your scheduled appointment time. We are located at 1410 Forum Katy Parkway, Columbia, MO 65203, and we can be reached by phone at (573) 441-7070.

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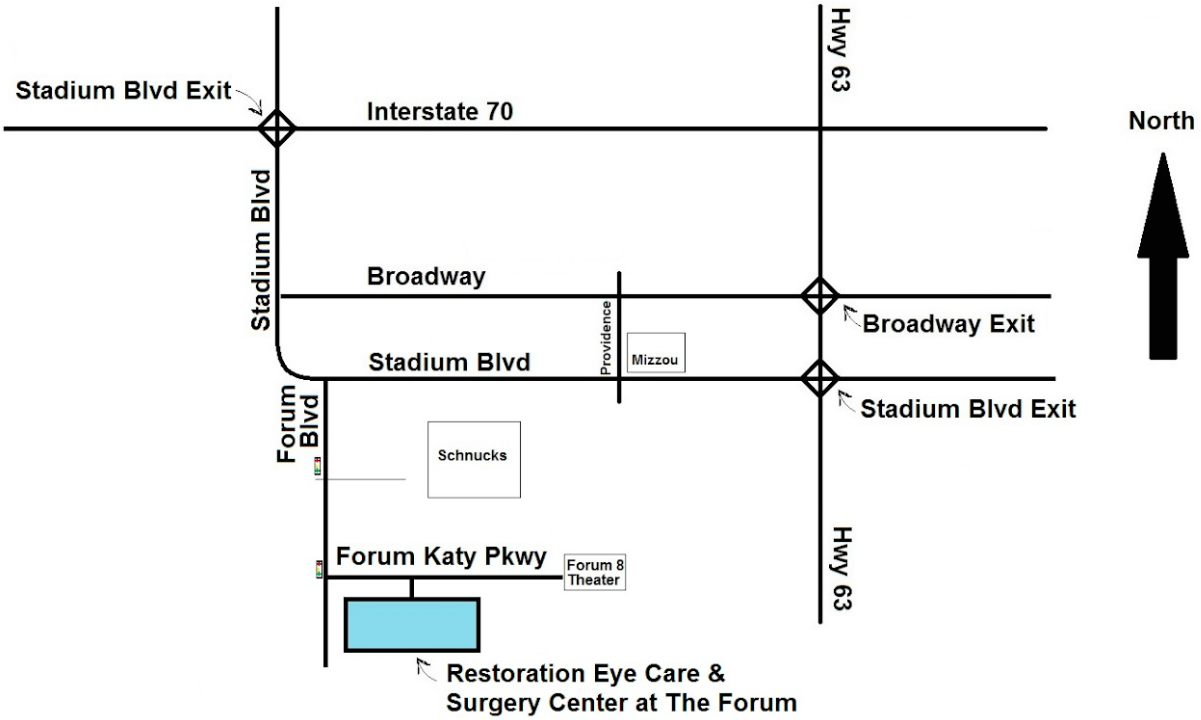
Directions to Columbia Location



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

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

From I-70

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

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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: _____
Insurance Company:_____ Card No._____

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

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

RESTORATIONEYECARE
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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**: _____

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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 (needing bifocals)
☐ Color Blindness
☐ Double Vision (Diplopia)
☐ Eye or Eyelid Cancer
☐ Facial Rosacea
☐ Eye Shingles (Varicella Zoster Ophthalmicus)
☐ Severe Eye Injury (Ruptured Globe)
☐ Farsightedness
☐ Tearing/Watering Constantly (Epiphora)
☐ Pupil Problems (Horner's Syndrome or Tonic Pupil)
☐ Cataract
☐ Cloudiness After Cataract Surgery (Posterior Opacification)
☐ Nearsightedness
☐ Lazy Eye (Amblyopia)
☐ Crossed or Turned Eyes (Strabismus)
☐ Droopy Eyelid (Ptosis)
☐ Eye Allergies (Allergic Conjunctivitis)
☐ Eye Herpes (HSV Keratitis)
☐ Keratoconus
☐ Eye Bone Fracture (Orbital Fracture)
☐ Cornea Infection (Ulcer)
☐ Dry Eye Syndrome
☐ Iritis/Uveitis
☐ Optic Neuropathy (NAION)
☐ Myasthenia Gravis

Patient Name:_____

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(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**

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

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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:_____

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

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

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

Gastrointestinal ☐Liver Disease ☐GERD (acid reflux) ☐N/A	**This section is used by the physician for updating purposes only:** For vital signs, see *Physician's Order & Authorization Note* H & P updated date and time of Physician's signature _____ _____**, M.D.** **Date**

Patient Name:_____

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