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.

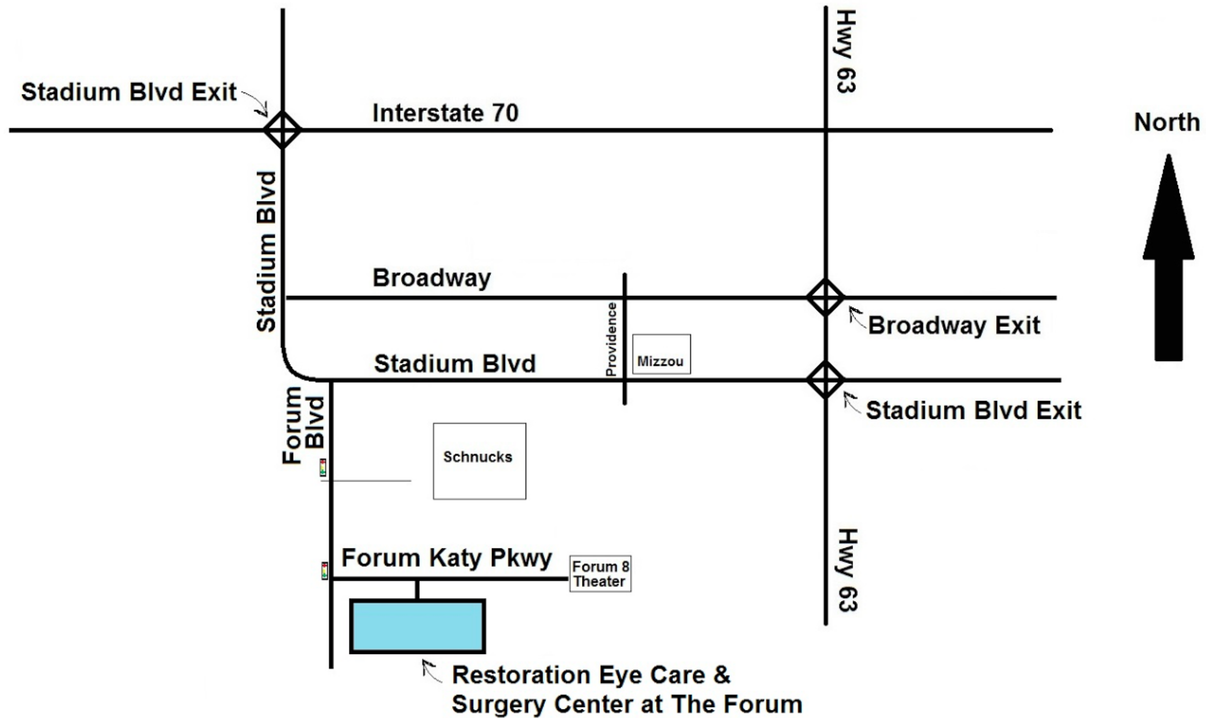
If you would like additional information about LASIK before your appointment, look us up on the web, **www.RestorationEyeCare.com**, or check us out on **Facebook.** If you are unable to keep this appointment, please call our office during regular office hours so that we will be able to schedule another 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

RESTORATIONEYECARE
TIMOTHY McGARITY, M.D.



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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TIMOTHY McGARITY, M.D.

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**: _________________

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

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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:________________________________

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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:____

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	**General**	**Allergy**	**Genitourinary**
☐Chest Pain ☐Irregular Heartbeat ☐Shortness of Breath ☐Heart Attack ☐Heart Valve Disease ☐N/A	☐Fatigue ☐Fever ☐Night Sweats ☐Weakness ☐Weight Loss ☐N/A	☐Chronic Runny Nose ☐Hives ☐Itching ☐N/A	☐ 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	**This section is used by the physician for updating purposes only:**
☐Liver Disease ☐GERD (acid reflux) ☐N/A	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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