**TYLOCK EYE CENTER**

**PATIENT REGISTRATION**

**PATIENT'S FULL NAME** ______________________________ Date ______________

Age ________ Sex _____ Birthdate ____________ E-mail ______________________

Home Ph. ( ) ______________ Business Ph. ( ) ______________ Cell ( ) ____________

_ Single _ Married _ Widowed _ Divorced _ Separated

Residence Address ______________________________________________

City ______________________________ State ____________ Zip ____________

Social Security # ________________ Driver License # ______________ State _________

Employer ______________________________ Occupation ______________________

Business Address ____________________ City ______________ State _____ Zip _________

Emergency Contact ______________________________________________

Address ________________________ City ______________ State _____ Zip _________

Relationship to Patient ______________________ Phone ( ) ______________

**NAME OF SPOUSE** (or parent, if dependent child) __________________ Employer ______________

Business Address ____________________ City ______________ State _____ Zip _________

Office Phone ( ) ______________ Social Security # ________________ DOB __________

Occupation ______________________________

PAYMENT FOR PROFESSIONAL SERVICES PERFORMED IN THE OFFICE IS DUE AT THE TIME OF THE VISIT. IF YOU ARE COVERED UNDER MEDICARE, MEDICAID OR WORKMAN'S COMPENSATION, PLEASE INFORM THE RECEPTIONIST.

METHOD OF PAYMENT: _ Check _ Cash _ MasterCard _ Visa _ AMEX _ Discover _ Medicare _ Medicaid _ Ins

How did you hear about our practice?

**IF SOMEONE OTHER THAN PATIENT IS RESPONSIBLE FOR PAYMENT, PLEASE COMPLETE THIS SECTION:**

NAME OF RESPONSIBLE PARTY ______________________ Relationship to Patient ______________

Address ________________________ City ______________ State _____ Zip _________

Employed By __________________ Wk Ph. ( ) ______________ Hm ( ) ____________

**MEDICAL INSURANCE INFORMATION: PRIMARY**

Name of Insurance Company ______________________________________________

Address ______________________________ Phone ( ) ______________

City ______________________________ State ______________ Zip ____________

Name of Policyholder ______________________ Precert. Phone # ( ) ______________

Social Security # of Policyholder ______________________ Group # ______________

Do You Need: _ Preauthorization _ Second Opinion _ Referral

**MEDICAL INSURANCE INFORMATION: SECONDARY**

Name of Insurance Company ______________________________________________

Address ______________________________ Phone ( ) ______________

City ______________________________ State ______________ Zip ____________

Name of Policyholder ______________________ Precert. Phone # ( ) ______________

Social Security # of Policyholder ______________________ Group # ______________

Do You Need: _ Preauthorization _ Second Opinion _ Referral

ASSIGNMENT OF BENEFITS

I hereby authorize the release of medical information necessary for insurance processing. I also request that payment of authorized insurance, Medicare and/or Medicaid benefits be made on my behalf to GARY R. TYLOCK, M.D. and such associates and other health care providers he may deem necessary, for any services furnished me by that physician and/or his assistants.

SIGNATURE ______________________________ DATE ______________

**PLEASE COMPLETE OTHER SIDE**

Please check any of the following that you have had:

_ Diabetes
_ High Blood Pressure
_ Heart Disease
_ Rheumatoid Arthritis
_ Cancer
_ Serious Eye Infection/Iritis
_ Serious Eye Injury
_ Eye Surgery
_ Ulcers or Colitis
_ Kidney Disease
_ Blood Clots
_ Bleeding Tendency
_ Asthma
_ Emphysema
_ Bronchitis
_ Other respiratory problems
_ Stroke
_ Thyroid Disease
_ Epilepsy
_ Retinal Disease
_ Glaucoma
_ Cataract
_ Tuberculosis

_ Other Significant Illness ______________________________

Please check any conditions that family members have had and indicate their relation to you:

_ Blindness
_ Cataract
_ Glaucoma
_ Retinal detachment
_ Crossed eyes/amblyopia (lazy eye)
_ Other serious eye disease

**Are you allergic to any medications? _ Yes _ No**

**If "Yes", please specify** ______________________________

______________________________

**PLEASE LIST ANY MEDICATIONS THAT YOU USE, INCLUDING HORMONES (birth control pills) AND PRESCRIPTION EYE DROPS:**

______________________________

______________________________

Date ____________ Updated ____________ Updated ____________ Updated ____________ Updated ____________

**Do you have a Living Will? _ Yes _ No**