# Dr. Thomas Tsai, O.D., PLLC & Associates Patient Registration and Health History Form

*(Please Print using Black Pen)*

Today's Date:_____/_____/_____

## Patient Information

Patient Name:_____
Last First MI

Address:_____ Apt:_____

City:_____ State:_____ Zip:_____

Home Phone: (_____)_____ Cell Phone:(_____)_____

Work Phone: (_____)_____ Employer:_____

Date of Birth:____/_____/_____ Age:_____ Sex: M / F

Race:_____ Status: Single / Married / Other

## Insurance Information

Primary Insurance:_____

ID #:_____ Group #:_____

Policy Holder's _____

Name & Address: _____

_____

Sponsor's Date of Birth: ____/____/____ Sex: M / F

Pt's Relationship to Sponsor: Self / Spouse / Child

Sponsor's Employer:_____

Sponsor's Tricare Status: Active / Retired Prime / Standard

## Eye History

Date of Last Eye Exam:_____ By Whom?:_____ Where?:_____

| Please √ Yes or No to the Following Questions: | Yes | No |
|---|---|---|
| Do You Wear Glasses? | | |
| Do You Wear Contact Lenses? | | |
| Are You Interested in Getting Contacts? | | |
| Are You Interested in Colored Contacts? | | |
| Are You Interested in Laser Surgery? | | |
| Do You Require Safety Glasses for Work/Hobbies? | | |

**Current Contact Lens Wearers Answer the Following:**

Current Contact Lens Brand: _____

How Long do a Pair of Lenses Last You? _____

Do You Sleep in Your Lenses? Y / N / Occasionally

Contact Solution Brand: _____

## Medical History

Primary Care Physician:_____ City,State:_____

**Medications:** Please list below all prescription and non-prescription medications you are currently taking.

**Allergies:** Please list all known allergies including medications and environmental.

**Surgeries**: Please list below any previous medical surgeries including those on the body or eye and any laser procedures:

**ROS**:

| Please √ Yes or No if You Currently Have or Had Any of the Following | | Yes | No | If Yes, Please Explain |
|---|---|---|---|---|
| Neurological Problems | (seizures, tremors, stroke) | | | |
| Ocular Problems | (lazy eye, retinal diseases, eye injury) | | | |
| Ear/Nose/Throat Problems | (hearing loss, sinus problems, sore throat) | | | |
| Respiratory Problems | (shortness of breath, wheezing, cough) | | | |
| Heart Problems | (chest pain, irregular heart beat) | | | |
| Gastrointestinal Problems | (heartburn, abdominal pain, diarrhea) | | | |
| Urinary Problems | (pain or discomfort, blood in urine) | | | |
| Musculoskeletal Problems | (muscle aches, joint pain, swollen joints) | | | |
| Skin Problems | (rashes, excessive dryness, rosacea) | | | |
| Endocrine Problems | (diabetes, thyroid problems) | | | |
| Psychiatric Problems | (depression, anxiety) | | | |
| General Health Problems | (chronic fever, fatigue, unexpected weight change) | | | |

***(Please flip page over for additional questions and signatures)***

**Family Medical History**

**Diseases/Conditions**: Please check below if **YOU** or a **PARENT, GRANDPARENT, or SIBLING** ever had any of the following:

| | Self | Family | | Self | Family | | Self | Family |
|---|---|---|---|---|---|---|---|---|
| Cataract | ☐ | ☐ | Thyroid Disease | ☐ | ☐ | Chronic Headaches | ☐ | ☐ |
| Glaucoma | ☐ | ☐ | High Blood Pressure | ☐ | ☐ | Seizures/Epilepsy | ☐ | ☐ |
| Eye Injury | ☐ | ☐ | Heart Problems/Disease | ☐ | ☐ | Arthritis | ☐ | ☐ |
| Crossed/Lazy Eye | ☐ | ☐ | Stroke | ☐ | ☐ | Lupus | ☐ | ☐ |
| Retinal Detachment | ☐ | ☐ | Anemia | ☐ | ☐ | Cancer | ☐ | ☐ |
| Macular Degeneration | ☐ | ☐ | Bleeding Problems | ☐ | ☐ | Liver Disease | ☐ | ☐ |
| Blindness | ☐ | ☐ | Asthma | ☐ | ☐ | HIV/AIDS | ☐ | ☐ |
| Diabetes | ☐ | ☐ | Kidney Problems | ☐ | ☐ | | | |

**Social Hx**

| | Yes | No | |
|---|---|---|---|
| Do you currently smoke or have smoked within the past ten years? | ☐ | ☐ | If yes, how much_____ |
| Do you drink alcohol? | ☐ | ☐ | If yes, how much_____ |
| Do you use recreational (including IV) drugs? | ☐ | ☐ | If yes, how much_____ |

**PUPIL DILATION IS AN OPTIONAL, BUT HIGHLY RECOMMENDED PART TO YOUR COMPLETE EYE EXAMINATION.**
The drops used in the dilating process opens the pupil of the eye allowing the doctor to see the entire retina. The larger pupil gives us the view necessary to evaluate the retina for such conditions as retinal detachments, holes, tumors, leaking blood vessels, etc. The most common side effects of the drops used in the dilating process are increased sensitivity to light and reduction in near focusing ability. **DISTANCE VISION is usually NOT significantly affected**. You should **BE ABLE TO DRIVE** if you feel confident doing so. If you do not have sunglasses with you, they will be provided. The effects last from 3 to 6 hours. We strongly advise dilation for our patients:

- -Over 50 Years of Age
- -With Nearsighted Vision over -5.00
- -Patients with **High Blood Pressure**
- -Patients with **Diabetes**
- -With Histories of Head or Eye injury
- -First Time Patients to this Office
- **-Children 10 Years of Age or Younger (Mandatory)**

***Check One:***

☐ **I DO give my permission for dilation drops to be installed in my eyes today.**

☐ **I DO NOT give my permission for dilation drops to be installed in my eyes today.**

**I have been informed of my privacy and health information rights and have been offered a copy of the privacy notice. Initials_____**

**FINANCIAL POLICY STATEMENT**

Welcome to Dr. Thomas Tsai, O.D., PLLC & Associates. We are pleased you have chosen our practice for your eye care. We are committed to providing you with the highest quality services available. We ask that you **carefully** read and sign the following policy. We must emphasize that, as your medical care provider, our relationship is with **you** and **not** your insurance carrier. As a courtesy to you, we will file your claim with your insurance company. However, **you are the sole responsible party for all charges incurred and guarantee payment** thereof. If we are contracted with your insurance company we will accept assignment. You will be responsible for your payment portion at the time of service. **Failure to provide necessary referrals and/or authorizations or failure to provide current, accurate billing information will result in all charges for services becoming the sole responsibility of the patient/responsible party**. You are expected to understand your benefits coverage and responsibility. This includes, obtaining any referrals and/or authorizations, which your insurance company requires **before** care is provided. All co-pays, co-insurance and deductibles are due and payable at the time service is rendered. If we do not have a contractual obligation with your insurance company, or you are a private pay patient, you are responsible for 100% of the payments at the time services are rendered. Failure to pay for services will result in collection action. All collection costs incurred by Dr. Thomas Tsai, O.D., PLLC & Associates, including attorney's fees, will become the sole responsibility of the responsible party named herein. Account balances not paid in full after 90 days will be turned over to a collection agency.

**I certify that I, and/or my dependent(s) have primary insurance coverage with the above-named insurance and assign directly to Dr. Thomas Tsai, O.D., PLLC and Associates all insurance benefits, if any, otherwise payable to me for services rendered. I authorize that the doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I understand that if my insurance plan denies payment, that I am responsible to pay for 100% of services rendered in full. I understand that if I have Tricare and a second health plan, Tricare will automatically become secondary and payment is due at time of service. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions and medical record release to health practitioners.**

In consideration of the services performed by Dr. Thomas Tsai, O.D., PLLC & Associates you agree to abide by the terms of this Financial Statement.

Patient's Signature *(or Guardian if minor)*_____ Date:_____

***Office Use Only:*** Doctor Reviewed History with Patient? Yes / No Date: _____/_____/_____ Initials _____