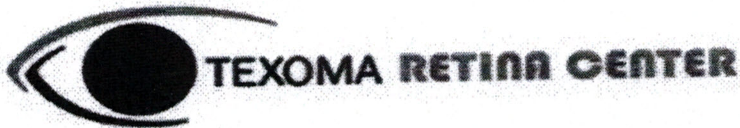


Please print clearly and answer ALL questions completely. How did you hear about our office? ___________________

Patient Information Are you allergic to Latex? Yes No Unknown (Ex. Tape, band aids, gloves)

Name_______________________________ Date of Birth_____________ Male / Female

Mailing Address__________________________ City ____________State ________Zip _______

Home#_________________Cell#___________________Work#______________________

Employer ________________________DL#________________SSN#__________________

Marital Status M S W D Spouse's Name______________________ *Email__________________

Emergency Contact _________________________Phone __________Relationship __________

Pregnant? Yes No Due Date__________________ Allergies to Medication__________________

Employment Status (Please circle one below)	Student Status (Please circle one below)	Race (Please circle one below)	
Full Time	Full Time	American Indian/Eskimo/Aleut	Hispanic/Latino
Part Time	Part Time	Asian	Pacific Islander
Retired	Not a Student	African American	Other (Multi Racial)
Not Working		Caucasian	

Who is your eye care provider? Optometrist/Ophthalmologist ______________________________

Insurance Information-write SELF if through patient

Name of Insured_____________________Date of Birth_______________Phone_______________

Mailing Address______________________City__________________State_______Zip_________

Relationship to Patient____________________SSN#_______________DL#__________________

List Insurance Providers that the patient is covered by

Primary Insurance___________________________ID#___________________Group#__________

Secondary Insurance_________________________ID#___________________Group#__________

If you have additional insurances please list them on the back of this page

***Email: I understand that this office will not be responsible for information loss or delay, or breaches in confidentiality that are due to technical factors beyond this office's control.**

Assignment of Benefits

I hereby assign all medical and/or surgical benefits, to include major benefits to which I am entitled, including Medicare, private insurance and any other health plan to Texoma Retina Center PA. This assignment will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as an original.

I certify that I have read and understand the 2015 Texoma Retina Center Office Policy

Signature of Patient____ Date___________________

OR if patient is a minor

Signature of Guardian____ **Date**___________________

PATIENT REGISTRATION FORM

TEXOMA RETINA CENTER PA- VIJAY KHETPAL, MD

Authorization to release protected health information, assign insurance benefits and finance unpaid charges.

I consent to the use or disclosure of my protected health information by Texoma Retina Center PA, for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations.

I understand that diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document. I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice.

I have the right to revoke this consent in writing excluding any action already taken before revocation.

I understand that Texoma Retina Center PA may call my home or other designated location and leave a message on voice mail or in person if reference to any items that assist the practice in carrying out treatment, payment and healthcare operations (TPO).

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan my employer or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or conditions and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand that my health information is protected and the protection is described by a document entitled Protected Health Information Policy. This policy many be occasionally revised. Simply by asking, I will be provided access to the current form of this document. Protected health information may be used to carry out treatment, payment, or health care operations. It is my right to restrict the use and disclosure of my protected health information. My doctor is not required to agree to these restrictions.

I authorize my insurance carrier to pay directly to Texoma Retina Center PA any benefits that my insurance plan (s) agrees to pay for services received. I agree to pay the balance that is approved but not paid from the insurance benefits.

Print Patient's Full Name: ______________________________ Date: ____________________

Authorizing Signature: ______________________________ Date: ____________________

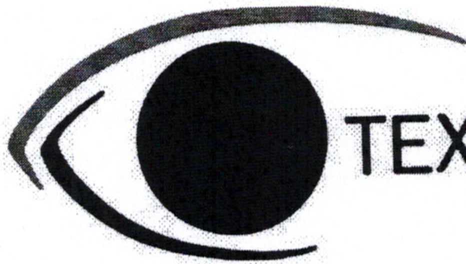
If indicated, print name of personal representative: ______________________________

If indicated, description of representative authority: ______________________________

List anyone we are authorized to discuss your protected health information with (family members, friends, or caretakers):

____

____



Vijay Khetpal MD

Board Certified Ophthalmologist, Specializing in Diseases of Retina and Vitreous

INFORMATION REGARDING DILATING EYE DROPS

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye.

Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it's best if you make arrangements not to drive yourself.

Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize Dr. Khetpal and / or his assistants as may be designated by him to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

______________________________ ______________
Patient (or person authorized to sign for patient) **Date**

______________________________ ______________
Witness **Date**

Address: 5012 S US highway 75, Suite 235, Denison TX 75020 |Ph: (903) 337-0055, Fax: (903) 337-0060

PATIENT HISTORY QUESTIONAIRE

FIRST NAME: ______________ **LAST NAME:** ______________ **DATE:** ________

REVIEW OF SYSTEMS: PLEASE CIRCLE AN ANSWER FOR EACH ITEM

EYES:

PREVIOUS SURGERY	YES/NO
CONTACT LENS	YES/NO
PAIN	YES/NO
DOUBLE VISION	YES/NO
GLAUCOMA	YES/NO
CATARACTS	YES/NO
MACULAR DEGENERATION	YES/NO
DRY EYES	YES/NO
FLASHES	YES/NO
FLOATERS	YES/NO

RESPIRATORY:

COUGH	YES/NO
CONGESTION	YES/NO
WHEEZING	YES/NO
ASTHMA	YES/NO

CARDIOVASCULAR:

CHEST PAIN	YES/NO
DIZZINESS	YES/NO
FAINTING SPELLS	YES/NO
SHORTNESS OF BREATH	YES/NO
IRREGULAR HEART BEAT	YES/NO
DIFFICULTY LYING FLAT	YES/NO

DO YOU DRINK ALCOHOL? YES/NO _IF YES, HOW MUCH PER DAY______________

DO YOU SMOKE NOW? YES/NO **ARE YOU A FORMER SMOKER?** YES/NO

DO YOU USE STREET DRUGS? YES/NO IF YES, WHAT TYPE______________

PLEASE LIST YOUR MEDICATIONS BELOW:

NAME OF MEDICATION	TIMES PER DAY	NAME OF MEDICATION	TIMES PER DAY

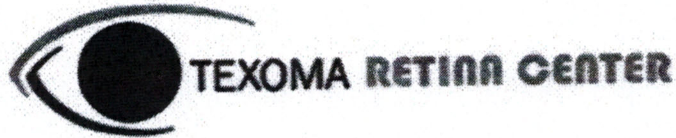
ALLERGIES AND DRUG REACTIONS:

FAMILY HISTORY: (PLEASE CIRCLE ANSWER FOR EACH ONE)

DISEASE:		RELATIONSHIP	DISEASE:		RELATIONSHIP
ARTHRITIS	YES/NO		HEART PROBS	YES/NO	
BLINDNESS	YES/NO		HYPERTENSION	YES/NO	
CATARACTS	YES/NO		KIDNEY PROBS	YES/NO	
CANCER	YES/NO		STROKE	YES/NO	
DIABETES	YES/NO		TB	YES/NO	
GLAUCOMA	YES/NO		RETINAL DISEASE	YES/NO	
LAZY EYE	YES/NO		MACULAR DEGEN.	YES/NO	

______________________________ PATIENT SIGNATURE

______________ DATE



We are committed to providing you with the highest level of service and quality care. If you have medical insurance, we will strive to help you receive your maximum benefits. In order to achieve these goals, we need your assistance and understanding of our financial policy. Ultimately, however, any and all financial liability rests with the patient.

Our office participates with most major insurance plans. We provide MEDICAL and SURGICAL ophthalmologic care to patients, as opposed to routine eye exams. If you have a managed care plan that requests a referral to see a specialist, **you must obtain a referral** in order for your visit in our office to be covered under your medical insurance. If you do not have the valid referral and still wish to be seen, you will be asked to pay for the visit prior to your examination. A refractive examination is not a covered service by most insurance companies, including Medicare. If refraction is performed, you will be charged for this service. We appreciate prompt payment in full for any outstanding balance. If you are unable to pay a balance in full, please notify our billing department immediately and we will work out a payment plan with you. Any check payments that does not clear the bank will be subject to a $25.00 returned check fee.

It is the patient's/parent's/guardian's responsibility to:

- Be familiar with the benefits of your plan, including co-pays, co-insurance and deductibles.
- Bring all of your current insurance cards to all visits.
- Provide our office with current information including address, phone numbers and employer.
- In accordance with your insurance contract, you must be prepared to pay your co-pay, coinsurance and deductibles at each visit. We accept cash, checks and all major credit cards for services.

On occasion the staff at Texoma Retina Center may help you in obtaining a referral however we are not responsible for this. If a referral is not obtained and cannot be obtained prior to the visit, you will have the choice of rescheduling the visit or paying the full fee at the time of the visit.

If you miss a scheduled appointment, please notify our office by phone the day before the appointment. Messages are acceptable and can be left at all times including evenings and weekends. Patients that arrive 15 minutes past their scheduled appointment time will be accommodated based upon schedule availability on the same day when possible. When there is no available appointment we will offer an appointment on the next available date.

For all services rendered to minor/dependent patients, we will look to the adult accompanying the patient and/or the parent or guardian with whom the child resides for payment. In cases of separation or divorce, when presenting insurance cards for a dependent enrolled under a subscriber other than you, please be prepared to supply their name, address, phone number, date of birth and social security number. We request that you inform the subscriber that their insurance has been used.

I request that payment of authorized Medicare and/or insurance benefits be made on my behalf to Texoma Retina Center for any services furnished to me by them. I authorize any holder of medical information about me to release to the Texoma Retina Center, its agents or any other insurance carrier I may have, any information needed to determine these benefits or the benefits payable to related services. This assignment will remain in effect until revoked by me in writing.

PATIENT WEB PORTAL

You can access your medical information by registering on the portal.

1. Go to www.myeyecarerecords.com
2. If you have logged in before, please insert your username (which is your email ID) and the password to access the portal.
3. For first time users, click the link Click Here link below the login bar.
4. Fill in all the information required along with your email ID which would be your username.
5. In the password tab, insert '1234' as the password and submit registration.
6. After the registration is completed successfully, it will prompt you to log in with the username and password.
7. Once you log in, it will direct you to view the document.

Frequently asked questions

What should I do if the registration is not accepted?
If the information you provided to us is different from what we have in our computer system, please contact our office at 903-337-0055 to rectify any errors.