

Thomas John Vision Institute
Patient Registration

Patient Name _____ Soc. Security # _____
Address _____ Birth date ____ / ____ / ____ Age _____
City _____ Marital Status (S) (M) (W) (D)
State _____ Zip _____ Sex (Male) (Female)
Home Phone (____) _____ Employer _____
Occupation _____ Employer Address _____
Work Phone (____) _____ City _____ State _____ Zip _____
Contact Person _____ Workmen's Comp? _____
Who referred you to Dr. John? _____
Emergency Contact Person
Name _____ Phone _____ Address _____

Person Responsible for Bill
Name _____ Phone _____ Address _____

Please present all insurance cards and photo ID at the front desk.

| | |
|----------------------------|----------------------------|
| Primary Insurance _____ | Secondary Insurance _____ |
| Insured's Name _____ | Insured's Name _____ |
| ID# _____ | ID# _____ |
| Patient Relationship _____ | Patient Relationship _____ |
| Ins. Address _____ | Ins. Address _____ |
| Ins. Phone _____ | Ins. Phone _____ |

***** Authorization to release information and assignment of benefits*****

**I authorize the release of any medical information necessary to process a claim.
I permit a copy of this information to be used in place of the original.**

Signature Date

I authorize Dr. John to apply for benefits on my behalf for covered services rendered by him, or by his order. I request for the party who accepts assignment.

This authorization may be revoked by either my insurance company or me at any time. I certify that the information I have reported is correct.

Signature Date

Referral Sheet

Patient Name: _____ Date: _____

**IN ORDER TO HELP US SERVE YOU BETTER
WE ASK THAT YOU PLEASE COMPLETE THE
FOLLOWING INFO:**

Who is your medical doctor?

Name _____

Address _____

City _____ State _____ Zip _____

Phone () _____

Who is your optometrist?

Name _____

Address _____

City _____ State _____ Zip _____

Phone () _____

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, Cornea Cataract & Laser Center originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communicating among many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have provided with a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Cornea Cataract & Laser Center is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Cornea Cataract & Laser Center reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Cornea Cataract & Laser Center change their notice, they will send a copy of the revised notice to the address I've provided.

I wish to have the following restrictions to use or disclosure of my health information:

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I fully understand and accept/decline the terms of this consent.

Patient's Signature _____ Date _____



THOMAS JOHN VISION INSTITUTE

Tinley Park Medical Campus
16532 S. Oak Park Av., Suite #201
Tinley Park, Illinois 60477
708-429-ABCD (2223)
Fax: 708-429-2226

www.drthomasjohn.com

10315 S. Cicero Av.
Oak Lawn, Illinois 60453
708-499-3939
Fax: 708-499-9986



Thomas John, M.D.
Clinical Associate Professor
Loyola University at Chicago

Honor Award 1996
American Academy of Ophthalmology

Refractive Surgery (LASIK)
Cornea and External Disease
Cataract and Implant Complications
Anterior Segment Surgery

"We Strive for Excellence in Eye Surgery"

*Chicago Top Doctor
Chicago Magazine*

*America's Top Ophthalmologist
Research Council of America*

*America's Top Doctor
Castle Connolly, Ltd.*

Editor of
2 Text Books
on Lamellar Keratoplasty

Surgical Procedures

LASIK
Clear Cornea
Phacoemulsification
(topical anesthesia, no-stitch)
Descemetorhexis with
Endokeratoplasty (DXEK/DSAEK)
Anterior Lamellar
Keratoplasty (ALK)
Corneal Transplant
(Penetrating Keratoplasty)
Aquaflow Surgery
(Deep Sclerectomy with
Collagen Implant
Amniotic Membrane
Transplant
Artificial Cornea/
Keratoprosthesis (K-Pro)
Glaucoma Surgery
Ahmed Valve (seton) with
Pericardial Graft
Scleral Graft
Scleral-fixated PC IOL
(sutured IOL)
Management of all
Anterior Segment Surgical
Complications
Pterygium Surgery with
Amniotic Membrane Transplant
Anterior Segment
Reconstruction

I, _____

understand that if I experience an eye- related problem
and Dr. Thomas John is not available, that I must go to
the nearest emergency room or call 9-1-1, if it is an
emergency.

Signed: _____

Date: _____

Awards (Partial List):

- First Place Awards for Surgical Video Competitions from the major Ophthalmic Societies:
- American Academy of Ophthalmology (2 First Place Awards, 2000)
 - American Society of Cataract and Refractive Surgery (1995) (First Place Award)
 - International Society of Refractive Surgery (2001) (First Place Award)

Landmark Surgeries:

First in the world to perform Amniotic Membrane Transplant for Toxic Epidermal Necrolysis (Ophthalmology 2002; 109:351-360)
First in Illinois and Indiana to perform DLEK 2002 (2nd in the Midwest and 4th in the nation)
One of the initial surgeons to perform Amniotic Membrane Transplant for Acute Alkali Burn (Ophthalmology 2000; 107:980-990)

Ophthalmology Training



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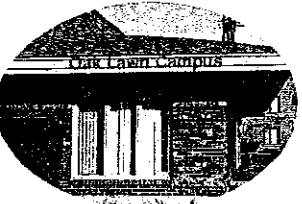
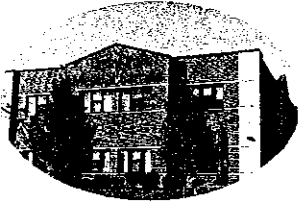
America's Top Ophthalmologist
Research Council of America

America's Top Doctor
Castle Connolly, Ltd.

Chicago Top Doctor, Chicago Magazine



Visiting Professor
Department of Defense, MMA, Beigrade



I _____ understand that if I do not cancel my appointment within 24 hours, I will be charged a cancellation fee of \$40.00.

Editor of 2 Text Books
on Lamellar Keratoplasty

Surgical Procedures

- LASIK
- Clear Cornea Phacoemulsification (topical anesthesia, no-stitch)
- Descemetorhexis with Endokeratoplasty (DXEK/DSAEK)
- Anterior Lamellar Keratoplasty (ALK)
- Corneal Transplant (Penetrating Keratoplasty)
- Amniotic Membrane Transplant
- Artificial Cornea/Keratoprosthesis (K-Pro)
- Glaucoma Surgery
- Aluned Valve (seton) with Pericardial Graft
- Scleral Graft
- Scleral-fixated PC IOL (sutured IOL)
- Management of all Anterior Segment Surgical Complications
- Pterygium Surgery with Amniotic Membrane Transplant
- Anterior Segment Reconstruction

Sign: _____

Date: _____

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Ophthalmology Training

Cornea Fellowship: Harvard Medical School, Massachusetts Eye and Ear Infirmary, Boston, MA