

Welcome to TransVision Eye Care! "We care more than your vision"

Chief Complaint: Loss of vision Blurred vision Double vision Dryness Redness Burning Itching
Foreign body sensation Swollen eyelids Eye pain Headache Migraine Eyestrain Discharge
Watery eyes Spots in vision See flashing lights Light sensitivity Other _____

Name _____ (Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr. <input type="checkbox"/> Date _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ Email _____
Patient's Date of Birth _____ Age _____ SS# _____ Spouse's Name _____
Name of Employer _____ Occupation _____
Special Vision Needs (work or hobbies) _____
Who referred you to our office? (Name) _____

Please circle if you have ever had the following? Allergy Dry Eyes Glaucoma Lazy Eye Macular Degeneration Cataracts Diabetes High Blood Pressure Thyroid Disease Migraine headache Do you smoke? Yes / No
Please list any medical conditions _____
List all medications _____
Are you allergic to any medications? Yes / No (List) _____
Have you ever had any injury or surgery to your eyes? Yes / No Describe _____
Have any blood relatives had glaucoma or other loss of sight? _____

Do you presently wear glasses? Yes / No Single Vision <input type="checkbox"/> Progressive <input type="checkbox"/> Bifocal <input type="checkbox"/> Trifocal <input type="checkbox"/> Reader <input type="checkbox"/>
Want New Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Are you interested in getting LASIK surgery? Yes / No
Do you presently wear contact lenses? Yes / No Gas permeable <input type="checkbox"/> Soft <input type="checkbox"/> Name _____?
If yes, how old are your current contact lenses? _____ If no, have you ever worn contact lenses? Yes / No
Do you have vision care insurance? Yes / No Name _____
Do you have medical health insurance? Yes / No Name _____
Person Insured _____ Date of Birth _____ SS# _____

PLEASE READ CAREFULLY. THANK YOU!

Signature on File: I hereby authorize payment of Medicare and other health insurance benefits to Dr. Huey T. Tran for professional services rendered. I authorized the release of any medical information necessary, including copies of medical records, for the determination and payment of benefits. I understand that Dr. Tran accepts assignment for Medicare, BCBSTX, Cigna, UHC, PHCS, Aetna, Unicare, HealthSmart and certain PPOs with which he is affiliated, and that I am responsible for any deductibles, co-pays and/or fees for non-covered services such as: office visits, refractions, non-medically related office visits, deluxe frames not covered by insurance and contact lens fitting. Contact lens patients must have a basic eye exam for glasses prior to contact lens fitting. Medical insurance will be filed for the medical eye exam. Vision insurance will be filed for glasses, CL fitting or CL supply.

Privacy Notices: This office privacy practices are in accord with HIPPA regulations. You may obtain a copy of our privacy practice at any visit.

Wellness Retinal Screening: To ensure good eye health and to prevent blindness, Dr. Tran recommends digital retinal photos of the back of your eyes. If done yearly, the photos create a continuous digital record of the eye health over time and are great tool for diagnosing common eye disease at the earliest stages. Digital retinal photos are an alternative to those patients who refuse dilation. There will be an additional fee of \$25 for this procedure and will NOT be covered by insurance.

Please check one: **Wellness Retinal Screening** **OR** **Dilation**

Responsible party's signature _____ Date _____

RTO: 24 HR 48 HR 1 WK 2WK 3WK 1MO 2MO 3MO 6MO 1YR CL GL DE RET HRT VF IOP OTHER _____