

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

Reasons of the Visit: Fluctuation of vision Problem with sight Blurred vision Visual Disturbances
Eyestrain Reduced Night Vision Halos around light Dryness Redness Burning Itching Eye pain
Foreign body sensation Swollen eyelids Headache Migraine Discharge Watery eyes Floaters
See flashing lights Light sensitivity Contact Lens Intolerance Diabetic Exam Glaucoma Exam
Follow up of eye disease Other _____

Name _____ (Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr. <input type="checkbox"/> Date _____
Address _____ Apt# _____ 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.

Responsible party's signature _____ Date _____

RTO: 24 HR 48 HR 1 WK 2WK 3 WK 1MO 2 MO 3 MO 6 MO 1 YR OTHER _____

CL GL DE RET HRT OCT VF OPTOMAP IOP OTHER _____

optomap®

Retinal Exam

At **TransVision Eye Care** we pride ourselves on providing our patients with the best possible standard of care. **Because of this we now perform the Optomap® Retinal Exam with all of our patients.** This non-invasive procedure allows Dr. Tran to see a much broader and more detailed view of the retina than possible with conventional methods. When reviewed, the scan becomes a permanent part of your medical file, enabling Dr. Tran to make important comparisons should potential vision threatening conditions show themselves at future examinations. **Dr. Tran strongly believes that the optomap® Retinal Exam is essential part of your comprehensive eye exam and prescribes to all patients once per year.**

As part of your pre-test work up we have captured **optomap®** images for review with Dr. Tran during your examination today. The \$35.00 co-pay for this procedure is generally a non-covered service unless being used to actively follow disease. Any questions you have about the **optomap®** Retinal Exam can be directed to Dr. Tran when he reviews the images with you during your examination.

Responsible party's signature _____ Date _____

Insurance Policy *(please read)*

We often have patients that have both vision and medical insurance. They are very different in terms of the services they cover and it's important for our patients to understand those differences.

Vision coverage is mainly designed to determine a prescription for glasses and is not equipped to deal with complex medical conditions and/or diagnoses and does not include a detailed examination of the retina.

When a medical diagnosis or condition is present (such as 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, diabetes, glaucoma, high blood pressure, long-term current use of high-risk medications, eye disease or family history of eye disease/blindness) it is necessary to file the visit with your major medical carrier and the co-pays for that insurance will apply as well as any non-covered services.

Our office does not make these rules and they are defined by the insurance carriers themselves.

There is no way to know prior to the examination which type of insurance our office will be able to file for you. We make every effort to be on every major carrier for your convenience and we will file those claims for you.

In the event that we do not take your major medical/vision insurance, we will provide you with an itemized receipt so that you may file with your carrier for reimbursement. If you have any questions, please let us know. Thank you very much for your cooperation.

I have read and understand the above stated insurance policy and agree to all its conditions.

_____ Date _____
Signature of responsible party