

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"/> Miss <input type="checkbox"/> Dr. <input type="checkbox"/>)		Date _____	
Address _____		Apt _____	City _____
State _____		Zip _____	
Home Phone _____		Cell Phone _____	Daytime/Work Phone _____
EMAIL _____			
Patient's Date of Birth _____		Age _____	SS# _____
Spouse's Name _____			
Occupation _____		Name of Employer _____	
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 _____	
Primary 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.
Payment Options: Most major credit cards and cash. **WE DO NOT ACCEPT CARE CREDIT OR CHECKS**

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 _____

(SMAP) (OPTOMAP) (DILATION) (REFRACTION) (RETINAL PHOTOS) (IOP) (VF) (MATRIX/ HFA3) (OCT ONH) (OCT RET) (CL FU) (ORDER CLS/GLS) OTHER _____

Patient Dilation Consent Form

Dilation, in lieu/conjunction with OptoMap is an important part of a comprehensive eye exam. Dilation drops will enlarge the pupil so that Dr. Tran can get a better look at the back of the eyes. It allows him to properly check for any problems that can occur from systematic diseases and physical changes.

Effects of Dilation

The dilation will make viewing close up difficult and make lights brighter than usual. Upon instillation of drops, there is a short (few seconds) of burning sensation. It then takes approximately 20-30 minutes for the drops to take effect. The effects can last between 4-5 hours. Most patients will be able to drive with their eyes dilated; with the aid of sunglasses. However, if you are uncomfortable with driving while your eyes are dilated, it may be best to have a designated driver. There are NO additional charges to have your eyes dilated the day of your comprehensive eye exam.

Please check one of the following boxes:

- I would like to have my eyes dilated today **if Dr. Tran believes it is necessary**
- I would like to schedule a time to come back for the dilation
- I do not want my eyes dilated.

Patient's Signature

Date

Print Name



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 recommends it to all patients once per year.**

If elected we will capture **optomap®** images for Dr. Tran to review during your examination today. **The \$45.00 fee for this procedure is considered a non-covered service through insurance.** 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.

- I **AGREE** to the **additional \$45.00** for the **Optomap®**, in addition to my regular routine eye exam copay set by insurance.

- I elect **NOT** to have the **Optomap®** Retinal Exam done today, **against the recommendation of Dr. Tran.**

I understand the benefits of the annual **optomap®** Retinal Exam as:

- Fast, easy and comfortable
- A permanent record to compare and track potential eye diseases.
- An in depth view of nearly the entire retina.
- Educational tool for your doctor to discuss your health and wellness.

I understand that a widefield view of the retina is an important part of a comprehensive eye exam and that I am declining the Doctor's recommendation to obtain a comprehensive view of my retina.

What is the reason(s) for Declination? _____

Responsible party's signature _____ Date _____