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.☐ Mrs.☐ Ms.☐ Miss☐ Dr.☐) 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☐ Progressive☐ Bifocal☐ Trifocal☐ Reader☐

Want New Glasses ☐ Contacts ☐ Are you interested in getting LASIK surgery? Yes / No

Do you presently wear contact lenses? Yes / No Gas permeable☐ Soft☐ 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) (REFACTION) (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

optomap®

ultra-wide digital retinal imaging

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_____

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.

In the event that your insurance denies your clean claim; you will be billed for the rendered services. Prior to receiving services, please provide **all** Medical and vision insurances; including but not limited to primary, secondary, and supplements.

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

_____Date_____

Signature of responsible party