WELCOME TO

OPTIMUM EYECARE

We are pleased that you have chosen our office for your vision care
Dr. Nga Vu-Tran O.D. & Dr. Anh T. Tran, O. D.

Name:	DOB:	Sex: M F	Date:
Address:	City:	State:	Zip:
Home#:	Work#:		Cell#:

How did you hear about our office? _____ Email_____

Whom may we contact in case of an emergency?

Name/Relation: _____ Phone: _____

Medical Insurance: _____ Vision Insurance: _____

Relation to Insured: Self___ Spouse ___ Child ___ Patient's SS#:_____

Primary Insured's Name: _____ Primary's SS#:_____ DOB:_____

Primary Insured's Employer:_____ Occupation: _____

Last Eye Exam: ____/____/____ Do you wear glasses? _____ Do you wear contacts? _____ Type?_____

Your reasons for visiting our office today (Please check all that apply):

___ Annual Check-Up
___ Blurred Distance Vision
___ Blurred Near Vision
___ Eye Infection
___ Headaches
___ Flashes/Floaters
___ Contact Lens problem
___ Want to know contact lens options
___ Soft (___ disposables ___ daily ___ colored)
___ Gas permeable

Please check any condition that applies to yourself or any members of your immediate family.

	Self	Family		Self	Family
Amblyopia (Lazy Eye)	____	____	Arthiritis	____	____
Blindenss	____	____	Cancer	____	____
Cataracts	____	____	Diabetes	____	____
Color Blindness	____	____	Heart Disease	____	____
Eye Tumors	____	____	High Blood Pressure	____	____
Glaucoma	____	____	Kidney Disease	____	____
Macular Degeneration	____	____	Lupus	____	____
Retinal Detachment	____	____	Stroke	____	____
Strabismus (Eye Turn)	____	____	Thyroid Disease	____	____
Other Eye Conditions:			Cholesterol	____	____
_____			Other:_____		

Please check YES or NO to the following:	YES	NO
Do you work on a computer?	____	____
Do you drive?	____	____
Do you have difficulty driving at night?	____	____
Do you have trouble with glare?	____	____
Do you participate in sports?	____	____
Are you a smoker?	____	____

List **all medications** taken presently: _____

Any **drug allergies**? If so, please list: _____

OPTIONAL TEST (RECOMMENDED AS A BASELINE)
COVERED BY INSURANCE

A **dilated fundus exam** is recommended for all patients especially those who have high amounts of nearsightedness, episodes of flashes or floaters, recent head trauma, or systemic disease such as diabetes and high blood pressure. It is a temporarily enlargement of the pupils to allow doctors to detect many eye diseases and disorders and ensure a comprehensive eye examination. The side effects includes a temporary blurred vision, especially at near, and light sensitivity.

_____**YES**, I accept a dilated fundus exam

_____**NO** , I decline a dilated fundus exam. I release the doctor from any liabilities related to the failure to diagnose or treat any eye condition, which could have been obtained through dilation.

Insurance Authorization: I hereby authorize the physician(s) indicated to furnish information to insurance carriers concerning my eyes' problems and/or treatments and I hereby irrevocably assign to the physicians all payments for services rendered to myself or to my dependents. I understand that I am financially responsible for all charges whether or not covered by insurance. A photocopy of this authorization shall be considered as effective and valid as the original.

Initials _____

Our office complies with **HIPAA - Notice of Privacy Rights**. If you would like a copy, please notify our staff.

PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE. THANK YOU.
ALL PROFESSIONAL FEES ARE NON-REFUNDABLE

X_____ _____
Signature of Patient or Responsible Party **Date**