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: _____

Emergency contact: 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
___Safety Glasses
___ 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	____	____
Blindness	____	____	Cancer	____	____
Cataracts	____	____	Diabetes	____	____
Color Blindness	____	____	Heart Disease	____	____
Eye Tumors	____	____	High Blood Press	____	____
Glaucoma	____	____	Kidney Disease	____	____
Macular Degeneration	____	____	Lupus	____	____
Retinal Detachment	____	____	Stroke	____	____
Strabismus (Eye Turn)	____	____	Thyroid Disease	____	____
Other Eye Conditions:			Other Diseases:		

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: _____

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 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**