6851 Matlock Rd, Suite 111
Arlington, TX 76002

PH#: (817) 419-8871
FAX#: (682) 558-8229

Patient Demographics

NAME: ______________________ DOB: ____ / ____ / ____
Last, First, Middle

ADDRESS: ______________________ CITY: ______________

______________________ STATE: ________ ZIP: ________

CELL#: ______________________ ALT#: ______________________

EMAIL: ____

Emergency Contact

NAME: ______________________ CELL#: ______________
Last, First, Middle

RELATIONSHIP: ______________________________________

Insurance Information

MEDICAL: ______________________ VISION: ______________________

ID#: ______________________ ID#: ______________________

PRIMARY INSURED'S NAME: ______________________ PRIMARY INSURED'S NAME: ______________________

RELATION TO PRIMARY: SELF / SPOUSE / PARENT / CHILD (Please circle) RELATION TO PRIMARY: SELF / SPOUSE / PARENT / CHILD (Please circle)

Medical History / Medical Information

LAST EYE EXAM: ______ / ______
Month Year

LAST ANNUAL/ PHYSICAL: ______ / ______
Month Year

FORM(S) OF VISION CORRECTION USED:

- □ Glasses
  - □ Single vision
  - □ Bifocals
  - □ Progressive
- □ Contact lenses
  - □ Dailies
  - □ Biweeklies
  - □ Monthlies

Please indicate your reason(s) for visiting our office today. Mark all that apply:

- □ Annual eye exam
- □ Blurred distance vision
- □ Blurred near vision
- □ Headaches
- □ Redness
- □ Dryness
- □ Flashes of light(s)
- □ Floaters
- □ Eye infection
- □ Contact lens issue(s)
- □ Interest in contact lenses
- □ Safety glasses

Dr. Nga Vu-Tran, O.D. Dr. Jonathan Pham, O.D. Dr. Anh T. Tran, O.D.
info@optimumeyecare.com www.optimumeyecare.com

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PLEASE INDICATE ALL MEDICAL HISTORY THAT APPLIES:

SELF	FAMILY	OCULAR CONDITIONS
		Amblyopia / lazy eye
		Blindness
		Cataracts
		Color blindness
		Diabetic retinopathy
		Dry eye syndrome
		Eye tumor(s)
		Glaucoma
		Macular degeneration
		Retinal detachment
		Strabismus / eye turn
		Other: ______

SELF	FAMILY	MEDICAL CONDITIONS
		Arthritis
		Cancer
		Diabetes ☐ Type I ☐ Type II
		Heart disease
		High blood pressure
		Kidney disease
		Lupus
		Stroke
		Thyroid disease
		Other: ______

PLEASE LIST ALL THAT PRESENTLY APPLY:

MEDICATION(S)
☐
☐
☐
☐ None

KNOWN DRUG ALLERGIES
☐
☐
☐
☐ No known drug allergies

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 ACKNOWLEDGE THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT THEY ARE COVERED BY INSURANCE. A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE & VALID AS THE ORIGINAL.

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

SIGNATURE: ______________________________ DATE: ______ / ______ / ______
OF PATIENT OR RESPONSIBLE PARTY

OUR OFFICE COMPLIES WITH THE Health Insurance Portability and Accountability Act (HIPAA). IF YOU WOULD LIKE A COPY OF OUR HIPAA POLICY FOR YOUR RECORDS, PLEASE NOTIFY OUR STAFF.

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