

# TransVision, P.C.

## PERSONAL INFORMATION (PLEASE PRINT CLEARLY)

Patient Name (Last Name, First Name, M.I.) SEX: <input type="checkbox"/> M <input type="checkbox"/> F		Today's Date	Date of Birth	Age
Address		City	State	Zip
Home Phone	Business Phone (Parent, if applicable)	Cell Phone	Occupation/Employer	
Name of Parent or Spouse		Grade (If Student)	E-mail Address	

## MEDICAL AND OCULAR HISTORY

Your Reasons for Today's Visit (check all items that apply)

General Check-up   
  Want new contacts   
  Blurred dist. vision   
  Eye infection   
  Foreign body removal  
 Want new glasses   
  Interested in contacts   
  Blurred near vision   
  Eye irritation   
  Other: \_\_\_\_\_

When Was Your Last Eye Exam? \_\_\_\_\_ Name of Last Eye Doctor & City \_\_\_\_\_

### REVIEW OF SYSTEMS

Do you currently, or have you ever had, any problems in the following areas:

- Constitutional:**  Weight loss/Gain  Fever/Chills  Insomnia  Fatigue  other(explain)\_\_\_\_\_
- Ear, Nose, Mouth, Throat:**  Allergies/Hay Fever  Sinus Congestion  Runny Nose  Post-Nasal Drip  Cough  Dry Throat Mouth
- Cardiovascular:**  Diabetes  Heart Pain  High Blood Pres.  Vascular Disease  High Cholesterol  other\_\_\_\_\_
- Respiratory:**  Asthma  Chronic Bronchitis  Emphysema  other \_\_\_\_\_
- Gastrointestinal:**  Chronic Diarrhea  Chronic Constipation  other\_\_\_\_\_
- Genitourinary:**  Frequent Urination  Urinary Tract Infection  Hernia  Kidney Stones  other \_\_\_\_\_
- Musculoskeletal:**  Rheumatoid Arthritis  Muscle Pain  Joint Pain  other\_\_\_\_\_
- Integumentary (Skin):**  Eczema  Rashes  Dryness  Itching  other\_\_\_\_\_
- Neurological:**  Headaches  Migraines  Seizures  other\_\_\_\_\_
- Psychiatric:**  Agitated  Memory Loss  Depression  Mood Swings  Suicidal Thoughts  other\_\_\_\_\_
- Endocrine:**  Thyroid  Other Glands  other\_\_\_\_\_
- Lymphatic/Hematologic:**  Anemia  Bleeding Problems  Ease of Bruising  other\_\_\_\_\_
- Allergic/Immunologic:**  Yes  No  other\_\_\_\_\_

List any medications you take \_\_\_\_\_

List any allergies you have \_\_\_\_\_

### SOCIAL HISTORY DO YOU.....

Drink alcohol?  No  Yes, if yes, type/amount/how long? \_\_\_\_\_

Use illegal drugs?  No  Yes, if yes, type/amount/how long? \_\_\_\_\_

Use tobacco products?  No  Yes, if yes, type/amount/how long? \_\_\_\_\_

Have you ever been exposed to or infected with:  Gonorrhea  Hepatitis  HIV  Syphilis  None

Are you pregnant and/or nursing?  No  Yes

### FAMILY HISTORY Do YOU or ANYONE in your family (living or deceased) have any of the following?

	NO	YES	Relationship
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other_____	<input type="checkbox"/>	<input type="checkbox"/>	_____

# TransVision, P.C.

## INSURANCE INFORMATION (PLEASE PRINT CLEARLY)

Name of Vision Insurance	Name of Policy Holder	Social Security Number	Date of Birth
Name of Medical Insurance	Name of Policy Holder	Social Security Number	Date of Birth

## SIGNATURE ON FILE

Your insurance is a method for you to receive reimbursement for fees you have paid to the optometrist for service rendered. Having insurance is not a substitute for payment. Many companies have fixed allowances or percentages based on your contract with them not with our office. It is your responsibility to pay in advance for the deductible, coinsurance, or any other balances not paid for by your insurance. We will assist you in receiving reimbursement as much as possible, but you are responsible in advance for your bill. By signing this statement you agree to be financially responsible for all charges.

\_\_\_\_\_  
Signature of Patient or Authorized Agent

\_\_\_\_\_  
Date

## ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

\_\_\_\_\_  
Signature of Patient or Authorized Agent

\_\_\_\_\_  
Date

## AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize this office to release my health information to insurance company, consulting physician, optical center, and/or contact lens vendor. The purpose (s) for the release are to determine benefits or the benefits payable for related services or only at the request of the individual/patient. This assignment will remain in effect until revoked in writing. A photocopy of this assignment is considered to be as valid as the original.

\_\_\_\_\_  
Signature of Patient or Authorized Agent

\_\_\_\_\_  
Date

## DILATED FUNDUS EXAM

Dilation is a procedure by which the doctor puts drops in your eyes to enlarge your pupils. We recommend that all our patients have their eyes dilated during the examination because the doctor is able to provide a more comprehensive eye evaluation and obtain a larger view of your retina to detect for eye diseases such as glaucoma, cataracts, tumors, and retinal detachments.

Dilation may temporarily blur your vision and make you more light sensitive (disposable sunglasses will be provided), but the benefits far out weigh the small annoyances. Therefore, we strongly recommend our patients have their eyes dilated whenever possible.

**THE FEE FOR THIS PROCEDURE IS \$19.00**

Do you want your eyes dilated today?

YES  NO

## DIGITAL RETINAL PHOTO EXAM

TransVision is committed to providing the best patient care possible. We are now offering high resolution Digital Retinal Photo Imaging to accurately document retinal findings. This test should be done every year since the eye's health can change at anytime, often without symptoms. Retinal photography is strongly recommended for patients with a history of diabetes, glaucoma, cataracts, high blood pressure, and high prescription. Depending on each patient's needs, the doctor may recommend both Digital Retinal Photo and dilation. The benefits of Digital Retinal Photo Exam compared to dilation are your vision is unaffected, it provides a permanent documentation of eye diseases and establishes baseline images to compare against future changes and both patient and doctor view images together, providing the best education and disease management.

**THE FEE FOR THIS PROCEDURE IS \$25.00**

Do you want a Retinal Photo Exam today?

YES  NO

If you chose not to have the above test performed, TransVision and their doctors will not be held responsible for any disease or pathology that goes undetected due to the lack of diagnostic information that could have been obtained from the retinal photo or dilation.

\_\_\_\_\_  
Signature of Patient or Authorized Agent

\_\_\_\_\_  
Date