TransVision, P.C.

PERSONAL INFORMATION (*PLEASE PRINT CLEARLY*)

Patient Name (Last Name, First Name, M.I.) **SEX: [] M [] 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 vison [] 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: [] Head aches [] 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	☐	☐	_____
Cataract	☐	☐	_____
Crossed Eyes	☐	☐	_____
Glaucoma	☐	☐	_____
Macular Degeneration	☐	☐	_____
Retinal Detachment/Disease	☐	☐	_____
Arthritis	☐	☐	_____
Cancer	☐	☐	_____
Diabetes	☐	☐	_____
Heart Disease	☐	☐	_____
High Blood Pressure	☐	☐	_____
Kidney Disease	☐	☐	_____
Other_____	☐	☐	_____

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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 PRATICES

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 $30.00

Do you want your eyes dilated today? ☐ YES ☐ UNSURE

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 <u>every</u> 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 $30.00

Do you want a Retinal Photo Exam today? ☐ YES ☐ UNSURE

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 _____

TRANSVISION, PC

Patient Health Screening and Attestation

Patient Name:	DOB:
Appointment Date:	

Due to the recent concerns regarding COVID-19 (Coronavirus), we are requiring patients to answer the following health screening questions:

Have you experienced any of the following symptoms in the last 14 days?

Fever	YES ☐	NO ☐
Cough	YES ☐	NO ☐
Respiratory issues / difficulty breathing	YES ☐	NO ☐
Fatigue	YES ☐	NO ☐
Runny / Stuffy Nose	YES ☐	NO ☐
Headache	YES ☐	NO ☐
Body Aches	YES ☐	NO ☐
Sore Throat	YES ☐	NO ☐

Have you traveled outside of Texas in the last 14 days? ☐ YES ☐ NO

Have you been in close contact with anyone who has traveled outside of Texas in the last 14 days? ☐ YES ☐ NO

Have you been in close contact with someone diagnosed with COVID-19 in last 14 days? ☐ YES ☐ NO

If you answered yes to any of the symptoms above, a member of our staff will reschedule your appointment for a future date with a 2 week waiting period.

If you are not experiencing any of the symptoms listed above, you must acknowledge your choice to proceed with your exam and/or treatment a er reading the statement below.

I acknowledge that due to the concerns of spreading COVID-19 (Coronavirus), the CDC is currently recommending that any non-emergent or elective medical care or treatments, including surgeries, should be rescheduled until the pandemic is no longer a risk. I, _____, have been given the choice to reschedule my exam and/ or treatment. I am choosing to continue with my exam and/ or treatment on _____.

_____ _____

Patient or Patient Representative Signature Date

_____ _____

Name Printed (If Patient Representative) Witness Signature