Ninh Tran, M.D. ■ Richard Braunstein, M.D. ■ Nary Chum, O.D.

Patient Information

Name _____ SS # (Last 4 digits):_____

Address _____ Phone (____) _____ (home)

City _____State _____Zip _____ Phone (____) _____ (work)

Birth Date _____ Age _____Gender ☐M ☐F Marital Status_____ Phone (____) _____ (cell)

Occupation_____ Primary Care Physician _____

Email _____ How were you referred to our office_____

Emergency Contact Person _____ Phone _____ Relation _____

Primary Insurance

Insurance Company _____

Subscriber's Info: Name _____ Birth Date _____ SS # (Last 4 digits) _____

Relation to patient: Self Spouse Parent Other _____

Address (if differs from above) _____City_____State_____Zip _____

Employer _____Occupation _____

Secondary Insurance

Insurance Company _____

Subscriber's Info: Name _____ Birth Date _____ SS # (Last 4 digits) _____

Relation to patient: Self Spouse Parent Other _____

Vision Insurance

Insurance Company _____

Subscriber's Info: Name _____ Birth Date _____ SS # (Last 4 digits) _____

Relation to patient: Self Spouse Parent Other _____

Assignment and Release

Non-Covered Services: Any care not paid for by your existing insurance overage will require payment in full at the time of service or upon notice of insurance claim denial. I understand the charges for refraction or contact lens services may not be a covered benefit of my insurance, and I agree to be responsible for these charges.

Signature on File / Assignment of insurance benefit: I hereby assign all medical or Medicare benefits to which I am entitled,private insurance and any other health plans to Ninh H. Tran, M.D. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

I have read, understood and agreed to the above financial policy for payment of professional fee. The patient is ultimately responsible for all professional fees.

Signature _____ Date _____

Patient History Questionnaire

Name: _____ Birth Date: _____ Date:_____

Last eye exam: ____/____/_____ By: _____

Last medical exam: ____/____/_____ Primary Care Physician: _____

Do you wear contacts? ☐ YES ☐ NO Type: _____
Are you pregnant? ☐ YES ☐ NO Due Date: _____
Are you nursing? ☐ YES ☐ NO
Do you smoke? ☐ YES ☐ NO If yes, how much?_____
Do you drink alcohol? ☐ YES ☐ NO If yes, how much?_____

Medications: _____
_____
_____
_____
_____

Allergies to Medications: _____

Eye Surgeries or injuries: _____

Circle any that apply		***Explain***
Eyes Glaucoma, cataracts, macular degeneration, eye injury, retinal disease, cross or drifting eye, lazy eye, dry eyes, double vision, pain, blurred vision	☐ YES ☐ NO	
Constitutional Fever, weight loss, other	☐ YES ☐ NO	
Cardiovascular Heart problems, hypertension, irregular heart beat	☐ YES ☐ NO	
Ears, Nose, Mouth, Throat Hearing loss, sinus problems, sore throat	☐ YES ☐ NO	
Respiratory Asthma, shortness of breath, wheezing, coughing	☐ YES ☐ NO	
Gastrointestinal Heartburn, abdominal pain, diarrhea, vomiting, ulcer	☐ YES ☐ NO	
Genitourinary Kidney failure, ovarian cancer, prostate cancer	☐ YES ☐ NO	
Musculoskeletal Muscle aches, joint pain, swollen ankles	☐ YES ☐ NO	
Integumentary (Skin) Skin rashes, excessive dryness	☐ YES ☐ NO	
Neurological Numbness, weakness, headaches, paralysis, stroke	☐ YES ☐ NO	
Psychiatric Depression, anxiety	☐ YES ☐ NO	
Endocrine Thyroid problems, diabetes	☐ YES ☐ NO	
Hematologic/Lymphatic Blood disorders, leukemia	☐ YES ☐ NO	
Allergic/Immunologic HIV, Lupus, seasonal allergies	☐ YES ☐ NO	
Other	☐ YES ☐ NO	

Family History: Do any medical or eye disease run in your family. If yes, please note relationship to patient.

☐ Glaucoma _____ ☐ High blood pressure _____
☐ Diabetes _____ ☐ Macular degeneration _____

Acknowledgement of Receipt of Notice of Privacy Practices

Ninh H. Tran, M.D., Privacy Officer 650 596-1999

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Signed: _____ Date: _____

Print Name: _____ Telephone: (____)_____

If not signed by patient, please indicate

Relationship: _____

Name of Patient: _____

Our top priority is to ensure a safe patient experience during this COVID-19 pandemic. In order to achieve this, we are limiting the number of people in the office. We kindly request that the **patient enters the office building alone**, unless they are a minor or if it is necessary to have someone accompany them. We appreciate your understanding and thank you for your cooperation.

Nuestra principal prioridad es garantizar una experiencia segura para el paciente durante esta pandemia de COVID-19. Para lograr esto, estamos limitando el número de personas en la oficina. Solicitamos que el **paciente ingrese solo al edificio de la oficina**, a menos que sea de edad o si es necesario que alguien lo acompañe. Agradecemos su compresnsión y gracias por su cooperación.