Ninh Tran, 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)

Email _____ ☐ Check box to opt out of text reminders

Occupation_____ Primary Care Physician _____

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: _____