Welcome to . Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. Any information we already have on file will appear on this form. Please review all completed areas to ensure that the information we have is current and accurate. If you have any questions, please do not hesitate to ask.

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Male ☐ Female

First Name | MI | Last Name | Preferred Name

Street Address | City | State Zip

Social Security Number | Date of Birth | Home Phone - Include Area Code | Preferred Number to Call

Email Address | Guardian | Person Responsible for Account

Emergency Contact | Emergency Phone

How were you referred to our office?

☐ Friend/Family ☐ School ☐ Advertisement ☐ Patient
☐ Insurance Listing ☐ Drive by ☐ Other ☐ Doctor

Who were you referred by?

PRIMARY INSURANCE INFORMATION

Name and Address of Primary Insurance Company | City | State Zip

M ☐ F ☐ Insured's First Name | MI | Insured's Last Name

Insured's Identification Number | Group Number | Insured's Date of Birth

Patient Relationship to Insured
☐ Self ☐ Spouse ☐ Child ☐ Other

Patient Status ☐ Single ☐ Married ☐ Other
☐ Full Time Student ☐ Part Time Student ☐ Employed

SECONDARY INSURANCE INFORMATION

Name and Address of Secondary Insurance Company | City | State Zip

M ☐ F ☐ Insured's First Name | MI | Insured's Last Name

Insured's Identification Number | Group Number | Insured's Date of Birth

Patient Relationship to Insured
☐ Self ☐ Spouse ☐ Child ☐ Other

Please Read:

In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and material are charged to the patient.The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks.

Payment from my insurance is to be paid directly to . I understand that will be billed as my primary insurance. I understand that billing any secondary insurance is my responsibility. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.I acknowledge that I have received your Notice of Privacy Practices. **All professional fees are Non-Refundable.**

Signature | Date

Name

PATIENT HISTORY AND INFORMATION

Race

☐ American Indian Or Alaska Native ☐ Other Race ☐ Refuse To Specify
☐ Asian ☐ White ☐ Not Disclosed
☐ Black Or African American ☐ Native American
☐ Native Hawaiian Or Other Pacific Islander ☐ Caucasian

Other Race

Ethnicity ○ Hispanic Or Latino ○ Not Hispanic Or Latino ○ Unknown

Preferred Language ○ English ○ Spanish ○ French ○ Italian ○ Russian ○ Portuguese

Height ft in cm/m ○ ft in ○ cm ○ m Weight ○ lbs ○ kg

PRIMARY CARE PHYSICIAN

Primary Care Physician and Clinic Name

Address of Primary Care Physician City State Zip Phone

REFERRING PHYSICIAN

Referring Physician and Clinic Name

Address of Referring Physician City State Zip Phone

HEALTH HISTORY

What is the main reason for today's exam ? When was your last exam ?

When was your last health exam ?

Past Illnesses or Injuries:

Past Surgeries:

Current Medications:

Current Eye Drops:

Medicines that cause reactions or sensitivities:

Specific Allergies:

EYE HISTORY

Glaucoma	○ Yes ○ No	Dryness	○ Yes ○ No	Strabismus (Crossed Eyes)	○ Yes ○ No
Cataract	○ Yes ○ No	Excess Tearing/Watering	○ Yes ○ No	Blurred Vision Distance	○ Yes ○ No
Macular Degeneration	○ Yes ○ No	Eye Pain or Soreness	○ Yes ○ No	Blurred Vision Near	○ Yes ○ No
Retinal Detachment	○ Yes ○ No	Foreign Body Sensation	○ Yes ○ No	Distorted Vision (halos)	○ Yes ○ No
Color Blindness	○ Yes ○ No	Infection of Eye or Lid	○ Yes ○ No	Double Vision	○ Yes ○ No
Headaches	○ Yes ○ No	Itching	○ Yes ○ No	Floaters or Spots	○ Yes ○ No
Glare/Light Sensitivity	○ Yes ○ No	Mucous Discharge	○ Yes ○ No	Fluctuating Vision	○ Yes ○ No
Tired Eyes	○ Yes ○ No	Drooping Eyelid	○ Yes ○ No	Loss of Vision	○ Yes ○ No
Amblyopia (Lazy Eye)	○ Yes ○ No	Redness	○ Yes ○ No	Loss of Side Vision	○ Yes ○ No
Burning	○ Yes ○ No	Sandy or Gritty Feeling	○ Yes ○ No		

GENERAL HEALTH CONDITION

Fever	O Yes O No	Respiratory (Asthma)	O Yes O No	Anxiety or Depression	O Yes O No
Weight Loss	O Yes O No	Gastrointestinal	O Yes O No	Thyroid, Diabetes	O Yes O No
Other Symptoms	O Yes O No	Kidney	O Yes O No	Blood/Lymph	O Yes O No
Ears,Nose,Throat	O Yes O No	Muscles,Bones,Joints	O Yes O No	Allergic	O Yes O No
Cardiovascular (high blood pressure etc.)	O Yes O No	Skin	O Yes O No	Are you?	☐ Pregnant ☐ Nursing
		Neurological (Multiple Sclerosis)	O Yes O No		

Name

MEDICAL HISTORY QUESTIONAIRE

FAMILY HISTORY

		Relationship To Patient			Relationship To Patient			Relationship To Patient
Lazy Eye	O Yes O No		Retinal Detachment	O Yes O No		High Blood Pressure	O Yes O No	
Blindness	O Yes O No		Strabismus (Eye Turn)	O Yes O No		Kidney Disease	O Yes O No	
Cataract(s)	O Yes O No		Arthritis	O Yes O No		Lupus	O Yes O No	
Color Blindness	O Yes O No		Cancer	O Yes O No		Stroke	O Yes O No	
Glaucoma	O Yes O No		Diabetes	O Yes O No		Thyroid Disease	O Yes O No	
Macular Degeneration	O Yes O No		Heart Disease	O Yes O No		Others	O Yes O No	

SOCIAL HISTORY

Current Occupation : _____ Years _____ Employer _____

SPECTACLE LENS HISTORY

Do you use a computer? O Yes O No How many hours/day? _____ Distance from Computer? _____

Do you drive? O Yes O No Mileage to work each way? _____

Do you have glare problems? O Yes O No

Do you have visual difficulty when driving? O Yes O No

Do you have problems with night vision? O Yes O No

Do you currently wear glasses ? O Yes O No Since _____

Type of glasses ☐ FullTime ☐ PartTime ☐ Distance ☐ Close

Glasses Owned ☐ SingleVision ☐ Bifocals ☐ Trifocals ☐ Backup ☐ Safety ☐ Sports ☐ Progressive

Have you had trouble in the past with glasses? O Yes O No _____

Do you wear sunglasses? O Yes O No Are your sun glasses your current prescription ? O Yes O No

SPECIAL EYEWEAR NEEDS

☐ Computer (special prescriptions, special anti-glare tints or coatings) ☐ Safety Glasses (gardening, woodworking, welding)

☐ Occupational (mechanics, plumbers, pilots) ☐ Sports/Hobbies (racquet sports, motorcycle)

CONTACT LENS HISTORY

If not a contact lens wearer, are you interested in trying contact lenses at this time ? O Yes O No

Have you ever tried to wear contact lenses? O Yes O No Reason for stopping? _____

Do you currently wear contact lenses? O Yes O No Since _____

Type and brand of contact lenses _____ Today's wearing time ? _____

How many hours/day ? _____ How many days/week ? _____

Please rate the following on a scale of 1-10, with 1 being POOR to 10 being EXCELLENT

	Right	Left		Right	Left		Right	Left
Lens Comfort	_____	_____	Distance Vision	_____	_____	Near Vision	_____	_____

What Solutions do you use? Cleaner _____ Disinfectant _____ Enzyme _____

Name

SOCIAL HISTORY

Do you use nutritional supplements (vitamins etc.)? ○ Yes ○ No

Do you engage in regular exercise? ○ Yes ○ No

Do you drink alcohol ? If yes, how much/often : ○ No ○ Occasional ○ 1 Per Day ○ 2-3/day ○ 4+/day

Do you smoke ? If yes, how much/often : ○ No ○ Occasional ○ 1/2 pack/day ○ 1 pack/day ○ 1+ pack

Smoking Status _____

Method of Tobacco Intake : ○ Smoking ○ Chewing

Do you use Illegal Drugs : ○ Yes ○ No

Hobbies/ Interests : _____

TSO TELFAIR
13425 UNIVERSITY BLVD, #800
SUGAR LAND, TX 77479

NAME:_____ **DATE:**_____

WE ARE COMMITTED TO EARLY DETECTION AND PREVENTION OF EYE DISEASES. WE STRONGLY RECOMMEND THAT ALL OF OUR PATIENTS RECEIVE BOTH TESTS AS PART OF THEIR COMPREHENSIVE VISUAL ANALYSIS. Please check the appropriate box below stating your preference.

Dilated Fundus Exam enables us to provide a more thorough ocular health analysis. With the dilated pupils, we get a better view inside the eyes that allows us to detect early signs and changes of ocular pathologies. A **Dilated Fundus Exam** is extremely essential for diabetics, hypertensives, high near-sightedness, and/or any history of other related ocular disease. We will perform dilation unless declined.

☐ I **DO NOT WANT** Dilated Fundus Exam

A **Visual Field Analyzer** is a highly computerized instrument that provides us a more thorough analysis of your fields of vision. **Visual Field Screening** can assist us in early detection of glaucoma, retinal problems, some neurological diseases and may diagnose causes of headaches. **There is additional fee for this test.**

☐ I **DO NOT WANT** Visual Field Screening ☐ I **DO WANT** Visual Field Screening

I understand that without this test certain eye disease and conditions may not be discovered. I agree to assume all risk associated with refusing this test, indemnify, hold harmless, and release Dr. Le, its employees and optometrists individually from any and all claims or liability whatsoever related to failure to diagnose and or treat any eye condition due to lack of diagnostic information which could have been obtained by this test.

_____ _____
PATIENT/ LEGAL GUARDIAN SIGNATURE **DATE**