A BETTER VUE
EYE PHYSICIANS, LLC

1333 3RD AVE. S., STE 301
NAPLES, FL 34102

TELEPHONE (239) 262-2020 FAX (239) 435-1084

Welcome to A Better Vue Eye Physicians! We are honored that you have chosen us as your health care provider. Our goal is to provide the highest quality care for all of our patients in a timely and respectful manner.

You will need to bring your insurance card and a photo ID with you for each appointment. Please let our staff know if you have had any information changes since your last appointment. If you are unable to provide us with your insurance card, your appointment will need to be rescheduled. You will be asked to fill out new registration forms annually so we may update your information.

All co-pays, deductibles and past due balances are expected at time of service.

We ask that you allow plenty of time to get to the office for your appointment. You may be asked to reschedule your appointment if you are more than 15 minutes late. We will strive to stay on time. From time to time, a patient emergency arises and we may be running late for your visit. You will have the option to re-schedule or stay to be seen and we will keep you informed of how long of a delay you may experience.

Please bring all of your prescription and over-the-counter medications with you at each visit.

Welcome to our practice and we thank you for choosing A Better Vue Eye Physicians for all your ophthalmic health care needs.

Sincerely,

A Better Vue Eye Physicians

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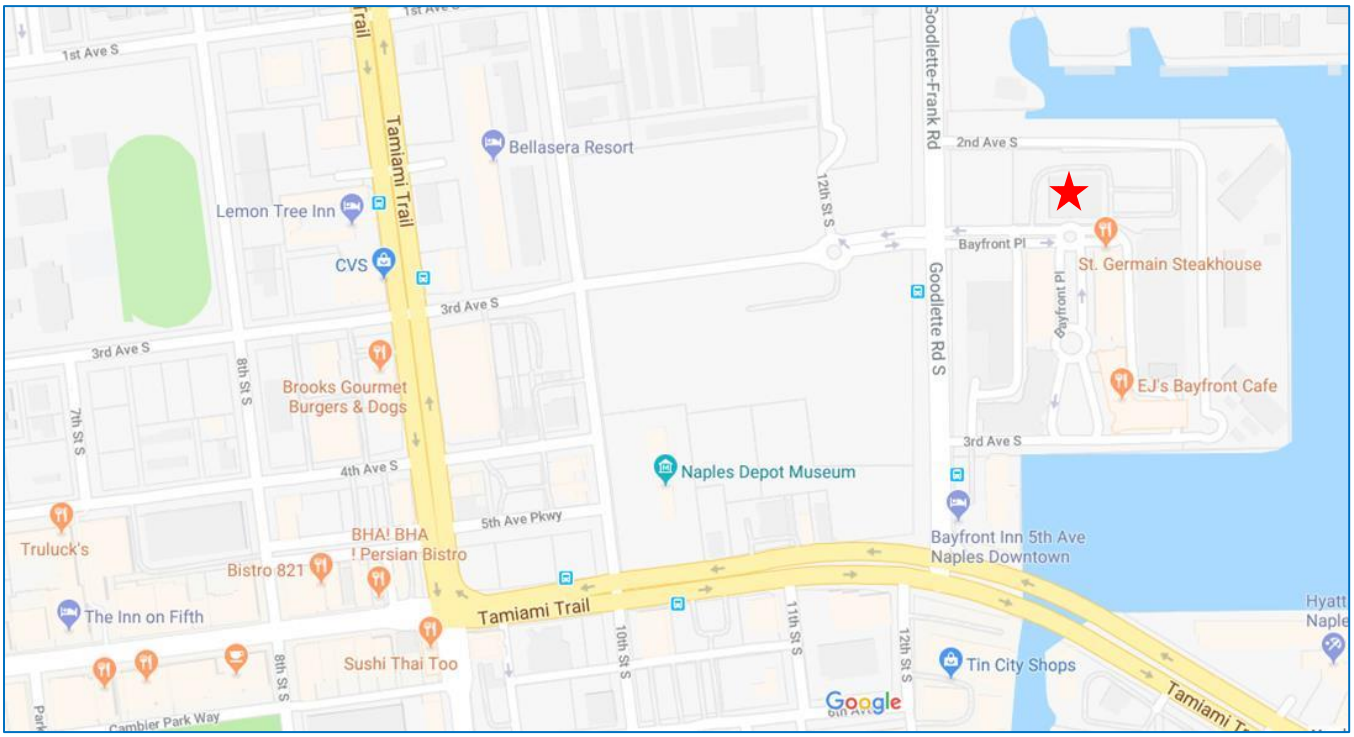
Directions to our office:



From US- 41: Turn North on Goodlette-Frank Rd. Turn Right at 3rd Ave. S (traffic signal). First building on your left.

From I-75: Take exit #105 (Golden Gate Blvd) West to Goodlette-Frank Rd., turn Left going South. Turn Left at 3rd Ave. S (traffic signal). First building on your left.

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DAVID D. TRAN, MD ~ LANI P. VU, MD
1333 3rd AVE. S., STE 301
NAPLES, FL 34102
TELEPHONE (239) 262-2020
FAX (239) 435-1084

Patient Registration

NAME:_____

SEX: ☐ MALE ☐ FEMALE MARITAL STATUS: ☐ M ☐ S ☐ D ☐ W AGE:_____

Social Security #_____ Date of Birth:_____

Local Address_____

_____

Home Phone:_____ Email:_____

Cell Phone:_____ Occupation:_____

Employer (Name and Address):_____

_____

Emergency Contact: (Name)_____ (Relationship)_____
(Address/Phone) _____

_____

Northern Address:_____

_____

Insurance Information

Primary Insurance:_____
Policy Holder (Name/SSN/DOB/Relationship if not self)_____

_____

Policy ID_____ Group ID_____

Secondary Insurance:_____
Policy Holder (Name/SSN/DOB/Relationship if not self)_____

_____

Policy ID_____ Group ID_____

Pharmacy Information

Name_____ Cross Streets_____ Phone_____

Name: Weight:_____Height_____
Date of Birth: Race_____

Medical History Form

Yes	No	Medical History: Do you have a history of any of the following?
		High blood pressure
		Diabetes
		Thyroid disease
		Heart disease
		Heart Attack
		Lung disease
		Asthma
		Neurologic disease
		Stroke
		Arthritis
		Cancer type?
		Hearing loss
		Kidney problems
		Bladder problems
		Anemia
		Seizures / Convulsions
		Weakness
		Weight Loss
		Liver disease
		Stomach ulcer

Yes	No	Eye History
		Cataracts
		Glaucoma
		Retinal Detachment
		Macular Degeneration
		Other Retinal Disease
		Laser Treatment
		Eye surgery type?

Yes	No	Have you experienced any of the following?
		Decreased vision
		Blind spots in vision
		Poor side visions
		Poor color vision
		Poor depth perception
		Abnormal sensitivity to light
		Halos around lights
		Problems with glare
		Red eye
		Eye discomfort
		Eye dryness
		Eye itching
		Pressure in or behind eye
		Crusting or red eyelids
		Tearing of eyes
		Double vision
		Flashing lights
		Jagged lines in vision
		Episodes of vision loss
		Lazy eye
		Spasm of the lids
		Serious eye infection
		Abnormal pupil

Yes	No	Family History
		Diabetes
		Heart Disease
		Retinal Disease
		Glaucoma

Have you ever smoked? ☐YES ☐NO packs per day_____ ☐QUIT? How long ago_____

Do you drink alcohol? ☐YES ☐NO frequency_____

Drug Allergies:_____

Medications:_____

Do you wear contacts / glasses / both? (please circle one)

Primary Care Physician:_____

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Dear Client:

Physicians, like all providers of personal / professional services, are now required by law to inform their clients of their policies regarding privacy of client information. Physicians have been and continue to be bound by professional standards of confidentiality.

We collect non public personal information about you that is provided to us by you or obtained by us with your authorization.

For current and former clients, we do not disclose any nonpublic personal information obtained in the course of our practice except as required or permitted by law. Permitted disclosures include, for instance, providing information to our employees necessary for your care, to your individual insurance companies and medicare as required for payment for claims for you, and to other physicians for the continuance of your care. In all situations, we stress the confidential nature of information being shared.

We retain records relating to professional services that we provide so that we are better able to assist you with your medical needs and to comply information, we maintain physical, electronic and procedural safeguards that comply with our professional standards.

If you have questions, feel free to ask, because your privacy, our professional ethics, and the ability to provide you with quality care are very important to us.

Sincerely,

A Better Vue Eye Physicians, LLC and Naples Premier Surgery Center LLC

Patient Consent for Use and DISCLOSURE OF Protected Health information

With my consent, the office of Drs. David Tran and Lani Vu (herein known as "The Practice") may use and disclose my protected health information to carry out treatment, billing, and healthcare operations.

The Practice reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy may be obtained physically in the office or by written request forwarded to the Practice office.

With my consent the Practice may leave messages:

	On my home answering machine		With my spouse
	With my children or anyone residing at my home		On my cell phone voicemail
	On my work voicemail		
	On my e-mail address. **leave address here:**		

I, _____ give permission to all my health care and medical providers and payors to disclose and release my protected health information described below to:

Name(s)	**Relationship**
_____	_____
_____	_____
_____	_____

I have the right to request that the Practice restrict how it uses or discloses my protected health information to carry out treatment, billing, and healthcare operations. However the Practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

I have the right to refuse to sign this authorization. If I do not sign this consent, the Practice may decline to provide treatment. I also have the right to inspect or copy the information to be used or disclosed.

PRINTED NAME:_____

SIGNATURE:_____

DATE:_____ Relationship to patient if other than self:_____