DOWNTOWN **OPTOMETRY**

Name: _____

Home Address: _____ **Zip:** _____
Cell: ( ) _____-_____ **Home:** ( ) _____-_____ **Work:** ( ) _____-_____

SS#: _____-_____-_____ **Birthdate:** _____/_____/_____ **Email:** _____

Occupation: _____ **Employer:** _____

Medical Insurance: _____ **Vision Plan:** _____

Who can we thank for referring you? _____

Family History

Diabetes	◯ **YES** ◯ **NO**	**If yes, Who:** _____
High Blood Pressure	◯ **YES** ◯ **NO**	**If yes, Who:** _____
Glaucoma	◯ **YES** ◯ **NO**	**If yes, Who:** _____
Macular Degeneration	◯ **YES** ◯ **NO**	**If yes, Who:** _____

Personal History

Diabetes	◯ **YES** ◯ **NO**	**Last Eye Exam:** _____
High Blood Pressure	◯ **YES** ◯ **NO**	**Last Medical Exam:** _____
Glaucoma	◯ **YES** ◯ **NO**	**Known Drug Allergies:** _____
Macular Degeneration	◯ **YES** ◯ **NO**	**Eye Surgeries/Injuries:** _____

Medications: _____

Do You Wear Glasses?	◯ **YES** ◯ **NO**	**If yes, How many Years:** _____
Do You Wear Contacts?	◯ **YES** ◯ **NO**	**If yes, How many Years:** _____

I agree to request the assignment of benefits directly to Dr. Tu for eye care services rendered to me. I understand that I am responsible for any service fees that are not covered by my Insurance and that payment is due upon services rendered.

Signature: _____ **Date:** _____/_____/_____

Acknowledgement of Notice of Privacy Practices

I understand that in an attempt to protect the privacy of my identifiable health information, Dr. Tu and Staff have established a Notice of Privacy Practices within their office. This information details the use and/or disclosure of information contained in my personal medical/optometric records kept for the purposes of diagnosis, treatment, payment, and health care operations. In accordance with HIPAA Regulations, a copy of the Notice of Privacy Practices is available to me in the office today. Should I choose to have a personal copy, one will be given to me.

Signature: _____ **Date:** _____/_____/_____