Drs. Au & Lau Optometrists, Inc. Patient Registration Form (OfficeUseOnly Acct # ______________)

Mr. ( ) Mrs. ( ) Miss ( ) Ms. ( ) Dr. ( ) Other _______ Sex: F ( ) M ( ) Marital Satus S ( ) M ( ) D ( ) W ( )

Name:____

(Last) (First) (Middle)

Birth Date:__________________ Age:_____ S.S#:________-_____-________ Nickname: __________________________

Address:____

City:______________________ State:_____________ Zip Code: _________ E-Mail: _____________________________

Phone #'s: ____

(Home) (Work) (Cell) (Pager / Fax)

Employer:____________________ What is your current occupation or Hobby? ___________________________________

Emergency Contact ____

(Name) (Phone#) (Address)

Are you currently taking any drugs, medications, or birth control? ( )No ( )Yes If yes, type and purpose if known.

____

Are you allergic to any medications? ( ) No ( ) Yes If yes, type: ____

Do you currently wear contact lenses? ( ) No ( ) Yes If yes, what type and brand:________________________________

Do you have vision or medical insurance? ( ) No ( ) Yes If yes, please continue on the next line.

____

Insurance Co. Subscriber's Name Subscriber # Group # Subscriber's DOB

HIPPA Privacy Acknowledgement of Receipt of Notice of Privacy Practices

I have been presented with the Notice of Privacy Policy (the "Policy") of Drs. Au & Lau, Opt., Inc. and have been offered a copy of such policy to keep for my records.

________ [Please initial here] I hereby acknowledge that I have been offered or provided with a copy of the policy.

Contact Lens Release Policy

________ [Please initial here] I understand that my contact lens prescription will be released to me **AFTER** completion of **ALL** of my follow-up visits.

Treatment and Insurance Policy

________ [Please Initial here] I authorize the staff of Drs. Au & Lau Opt., Inc. to administer such treatments as resonable or may be necessary in connection with the condition for which I or members of my family have sought care. And to the extent necessary to determine the liability for payments and to obtain reimbursement I hereby authorize Drs. Au & Lau Opt., Inc. to apply for benefits on my behalf for covered services rendered by them. I also request that all payments from the agreed third party be made directly to Drs. Au & Lau Opt., Inc. I agree to assume responsibility of full payment pending any remaining balance that is not covered by the agreed third party. I certify the information I have reported on my insurance coverage is correct.

I understand payment is due at the time services are rendered unless other arrangements have been made.

Signature:____ Date:________________________

(If patient is under 18, parent signature is required)