Welcome to the office of Dr. Hongbin Xu, Doctor of Optometry

Patient information

Name: _____ Birthdates (DOB):_____ Sex:_____
Address: _____ City: _____State: _____ Zip: _____
Home Phone: _____Cell Phone: _____Email: _____
Name of Employer: _____Occupation:_____
Medical Insurance: _____ Vision Insurance: _____
Subscriber Name: _____Subscriber Date of Birth: _____
Subscriber's ID or SSN: _____Patient's relation to subscriber: _____
Primary Care Physician: _____ Tel: _____
Address: _____ City: _____State:_____ Zip: _____
Referred by: _____ When was your last eye examination? _____

Assignment and Release

I hereby authorize **Dr. Hongbin Xu** to provide any treatment in the course of my examination. I authorize payment of benefits directly to Dr. Hongbin Xu for services rendered. I also authorize release of any medical information that may be required in determination of such benefits.
I understand that some services may require approval of my primary care physician for coverage and that, if I do not obtain that approval, I am financially liable for the services. I understand that my insurance carrier may not cover some services and products and benefit information does not constitute approval of payment. Deductibles and Fees not paid by my insurance carrier will be my responsibility.
I acknowledge that I received a copy of Dr. Hongbin Xu's "Notice of Privacy Act, HIPPA" policy.

Signature: _____ Date: _____

Medical History Questionnaire

Family/Personal History

What's the eye problems are you currently having? Please circle:

Blurred vision	Redness	Mucous discharge
Distorted vision/halos	Burning	Foreign Body sensation
Loss of side vision	Itching	Sandy or gritty feeling
Double vision	Dryness	Chronic eyelid infection
Flashes/Floating spots	Watering excessively	Eye pain of soreness
Crusting on eyelashes	Contact lens trouble	Other:

Do your have any of the following eye conditions? Please Circle:

Glaucoma Blindness Diabetic eye disease Macular degeneration
Cross-eyes/ Lazy eye Retinal disease/ Retinal detachment

PLEASE TURN OVER

Do you have any of the following medical conditions? Please Circle all that apply

Headaches	Allergies/hay fever	Asthma
Diabetes	Migraine	Sinus congestion
Chronic bronchitis	Heart/chest pain	Bleeding disorder
Runny nose	Emphysema	High blood pressure
Strokes/seizures	Cancer	Fever, weight loss/gain
Chronic cough	Arthritis	High cholesterol
Thyroid disease	Diarrhea/constipation	Dry throat/ mouth
Fibromyalgia	Psoriasis or rosacea	Kidney/ bladder disease
Lupus	Depression	Heart disease

Other: _____

Do any blood relatives have any of the following conditions? Circle all that apply

Blindness Diabetic eye disease Macular degeneration
Cross-eyes/ Lazy eye Retinal detachment Glaucoma
Cancer Diabetes High blood pressure
Thyroid disease Retinal disease High cholesterol other: _____

Social History

Do you drive? YES NO
Do you consume alcohol? YES NO
Do you use tobacco products? YES NO
Are you a carrier of, or infected with Hepatitis HIV Gonorrhea/ Syphilis
Marital/Living status: Single/Married/Divorced/Widowed; Live Alone/Live with Friends

Medical History

Please list all medications you are taking:

When was your last physical examination?
Who is your primary care physician?
Are you pregnant? YES NO
Are you allergic to any medications? YES (please list) NO

List all major surgeries or injuries:
Do you wear glasses? YES NO
Do you wear or wish to be fitted for contact lenses? YES NO
Contact Lens History: Soft RGP (Hard) Lens (Please circle)
Brand name: _____ Solution use: _____

Your signature: _____ Date: _____

Doctor's signature: _____ Date: _____