Unique Optometry

Snow Hu, OD, INC.

4390 Mission Street
San Francisco, CA, 94112
Tel: (415) 585-4966
Fax: (415) 585-4336
contact@uniqueoptometry.com

Patient's Information Record

Date: _____

First Name: _____ Last Name: _____MI: _____

Birthday: _____ Age: _____ ☐ Male ☐ Female Preferred Pronoun:_____ Last 4 digits SSN#:_____

Address_____

City_____ State:_____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____

Employer (or School): _____ Occupation (or Grade): _____

Emergency Contact Name(s): _____ Emergency Contact Phone #: _____

Relation to Emergency Contact: _____

Who may we thank for referring you?_____

Insurance Information

Vision Insurance：_____Primary Member's Name：_____

Primary Member's Birthday：_____ Primary Member's Last 4 digits SSN #：_____

Do you have a flex spending account: ☐ Yes ☐ No

Preferred Method of Contact: □ Phone: Home/Work/Cell (please circle option) □ Text/SMS □ Email

Financial Policy, Release of Information, & Assignment of Benefits

Unique Optometry extends the courtesy of filing to your insurance company. However, insurance coverage is a contract between you and your insurance company, and you are ultimately responsible for the payment of services rendered. I agree that all co-payments and /or deductible amounts due will be paid at the time services are rendered, unless payment arrangements have been made. I authorize payment of medical benefits directly to Snow Hu,O.D. INC for services rendered and allow the release of any information necessary to obtain payment.

Acknowledgement of Receipt of Privacy Practices & General Consent

I acknowledge that I read and received or was offered a copy of Unique Optometry's Notice of Privacy Practices. I further consent to the release of my health information for purposes of treatment, payment and health care operations and as authorized or required by law under the circumstances described in the Notice of Privacy Practices.

_____ _____

Signature of Patient, Parent / Guardian Date of signature