

MINTZ FAMILY OPTOMETRY
563 NORTH MOUNTAIN AVE
UPLAND, CA 91786
909-985-2876 FAX 909-946-8585

Date _____

Name _____

We would like to thank you for returning to see us. We would like to update our records.

I have confirmed my current address and home phone number with the receptionist.

My cell phone number is _____.

My email address is _____.

I am coming to see you today for my main concern of _____.

The doctor needs to be made aware of any changes to your health in the last year—please list below. _____

I am now under these new medications: _____

I am familiar with the retinal imaging offered to me for a fee of \$20 and realize it is highly recommended for patients with high blood pressure and diabetes as it spots eye disease under magnification and therefore a diagnosis may be quicker than through the typical eye exam. I would like this done (yes). _____ I would like to pass on this test at this time (no). _____

I acknowledge that I am authorizing Mintz Family Optometry to release information to determine benefits and submit an insurance claim. I also realize I will be responsible for any portion not covered by my insurance company.

Signature _____

We thank you as this is required by insurance auditors.

Lethuy Nguyen, O.D. and Associates