Sacramento Contact Lenses & Optometry, INC.

PATIENT INFORMATION UPDATE

Date: _____/_____/20____ Patient Name: _____

Address: _____City_____State_____Zip_____

Phone: Home_____Work_____Cell_____

Employer_____Occupation_____

Email_____ How do you prefer to be contacted? Email Phone

Medical Ins. Co._____ Insurer's ID #_____

Vision Ins. Co._____ Insurer's ID #_____

Do you participate in a flexible or health spending account? YES NO

Please record any changes to your medical history in the space below. Changes may include new medications, allergy to drugs, or pregnancy. If there are no changes, Please write **"No Changes".**

_____

_____

Visual Complaints:

_____

Emergency Contact: Name: _____ Phone Number: (___) _____

Signature of Patient or legal guardian_____

Please remember that your insurance is not a guaranteed form of payment. If your insurance Company denies your claim for any reason you are responsible to pay any remaining balance.

Update reviewed by Dr._____

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