SACRAMENTO
OPTOMETRIC GROUP
~TRUSTED VISION AND EYE HEALTH CARE~

TITLE: ( )Mr. ( )Mrs. ( )Miss ( )Ms. ( )Dr. Nick Name_____

Name (First)_____(MI)_____(Last)_____

Address_____City_____Zip_____

Primary Phone_____Secondary Phone_____Driver's License #_____

Date of Birth _____ SSN#_____ E-mail_____

Employer (or School)_____

Occupation_____Work Phone:_____

Name of Spouse/Partner_____Daytime Phone_____

In Case of Emergency, Contact_____Phone_____

Communication Preference: Telephone Postal Mail E-mail Texting Cell#:_____

At any point in your decision making process, did you: _____visit our web site _____search for us on your insurance web site
_____visit our facebook page _____read any online reviews about us

PLEASE COMPLETE THIS SECTION FOR MINOR A CHILD: Parent(s) we are authorized to release information:

Mother's Name_____Father's Name_____

To Protect your privacy, we are unable to release information regarding appointment scheduling, account financials, insurance information, picking up eyewear and/or diagnosis or treatment you have received unless authorized by you.

Name of Authorized person (s)	**Date of Birth**	**Relationship to Patient**

INSURANCE INFORMATION: Primary Insurance coverage:_____

Name of Insured _____Date of Birth:_____

Home Address _____City_____Zip_____
( ) same as above
Primary Phone _____SSN#_____Relationship to Patient_____

Any Additional Insurance coverage?

****Please provide your insurance cards to the receptionist so that we may make copies to assist us in billing and referrals****

( ) REFERRED BY_____May we send a thank you card? YES NO

_____I acknowledge that I viewed a copy and/or received a copy of the Notice of Privacy Practices for this office.
Initials

_____**APPOINTMENT CANCELLATION POLICY:** Circumstances have caused us to enforce a policy of charging for no-show
Initials appointments and scheduled appointments not cancelled within 24 hours. For any scheduled appointment that is cancelled the same day of your reserved appointment or not showing up for the reserved appointment will have a fee of $25.00 charged to their account.

RELEASE OF INFORMATION: I hereby authorize Sacramento Optometric Group to furnish and disclose all known facts concerning my care to my insurance company and to other physicians in managing my eye health. A copy of this authorization shall be valid as the original.
ASSIGNMENT OF BENEFITS: I hereby authorize my insurance company(s) or fund to make payment directly to Sacramento Optometric Group of any insurance benefits otherwise payable to me, for professional services rendered to date, but not to exceed the stated charges for these services. ***I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES THAT ARE NOT COVERED BY MY INSURANCE. I AGREE TO PAY COLLECTION COSTS, IN THE EVENT THAT FURTHER ACTION BECOMES NECESSARY TO ENFORCE THIS CONTRACT.***

_____Today's Date_____
Signature of Patient or Responsible Party