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 CHILD:

Mother's Name_____Employer_____

Father's Name_____Employer_____

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 received a copy of the Notice of Privacy Practices for this office.
Initials

_____**MISSED APPOINTMENT FEE:** If you are unable to keep your schedule appointment a 24 hour notice must be given. Same day
Initials cancellations or no shows for your reserved appointment will incur a charge of $25.00.

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 upon my request. 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. IF AUTHORIZATION IS REQUIRED FOR THE VISIT BUT IS NOT ABLE TO BE OBTAINED, I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR PAYMENT. WHEN I PLACE AN ORDER FOR MATERIALS (GLASSES OR CONTACT LENS) I UNDERSTAND THAT THERE MAY STILL BE A CHARGE TO ME IF NOT CANCELLED ON THE SAME DAY AS ORDERED. 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