Patient Information Update

Today's date: _____

Name: _____

Address: _____

_____ Zip:_____

Contact numbers: Home _____
Work _____
Cell _____

Is there any change in your health or medication since your last exam here?

Y N

If yes, please explain:

_____

Are you allergic to any drugs or medications?

Y N

If yes, please explain:

_____

Is there any change in your vision or your eyes since your last eye exam?

Y N

If yes, please explain:

_____

Current Insurance / Vision Benefit_____

Have you changed insurance carriers? Y N
(If yes, please present your insurance card)

I hereby grant my insurance carrier to pay Eye Associates directly.
I understand that if my insurance carrier doesn't cover all or part of my expenes, I am responsible for payment in full. This includes all late fees, legal fees and other costs incurred to collect my balance.

Signature of patient or guardian _____

Reviewed with patient by: _____
Doctor's signature Date