# RETURNING PATIENT UPDATE

(Please Print)

## RETURNING PATIENT INFORMATION

| Patient's Last Name | First | Middle | Today's Date / / |
|---|---|---|---|
| Street Address | | | Home Phone No. |

❑ The above contact information is correct and my contact information has not changed
❑ The above information is incorrect, I will update this information in the gray box 1 below

## INSURANCE INFORMATION

PLEASE PRESENT INSURANCE CARD AT THE RECEPTION DESK

| Primary Insurance Co. | Policy # |
|---|---|

❑ The above insurance information is correct and my insurance information has not changed
❑ The above information is incorrect, I will update this information in gray box 2 below

## VISUAL EXPERIENCE *(please check all that apply)*

| | | | |
|---|---|---|---|
| ❑ Blur - Distance | ❑ Eye Redness | ❑ Burning Sensation | ❑ Eye Itching |
| ❑ Blur - Near | ❑ Dry Eye | ❑ Tearing or Watery Eyes | ❑ Loss of Side Vision |
| ❑ Blur - Mid/Computer | ❑ Difficulty Seeing at Night | ❑ Headaches | ❑ Double Vision |
| ❑ Eye Pain | ❑ Light Sensitivity | ❑ Eye Strain | ❑ Glare Sensitivity |
| ❑ Halos | ❑ Floating Spots in Vision | ❑ Flashes of Light | ❑ Sensitivity to Artificial Light |

## VISUAL DEMANDS *(please check all activities that you engage in while wearing eyewear)*

| | | |
|---|---|---|
| ❑ Computer Work ________ Hours | ❑ Sports Activities | ❑ Outdoor Activities |
| ❑ Detailed Reading ________ Hours | ❑ Occupational Driving ________ Hrs | ❑ Work in Safety Environment |

## CONTACT LENSES *(please check if applicable)*

My current contacts are comfortable ❑Yes ❑No | I would like to try contact lenses ❑Yes ❑No

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I have read and understand the privacy policy I signed on my first visit. I understand that this policy is available for review. I understand that I am financially responsible for any balance. I also authorize Madeira Optical and my insurance company to release any information required to process my claims.

X ____________________________________________

PATIENT/GUARDIAN SIGNATURE DATE

### 1. PATIENT'S NEW CONTACT INFORMATION

| Street Address | City | State | ZIP Code | Home Phone No. |
|---|---|---|---|---|

### 2. PATIENT'S NEW INSURANCE PLAN

PLEASE PRESENT INSURANCE CARD AT THE RECEPTION DESK

| Insured's Name | Insured's S.S. # | Birth Date / / | Primary Insurance Co. | Policy # |
|---|---|---|---|---|

Patient's Relationship to Insured ❑ Self ❑ Spouse ❑ Child ❑ Other