WELCOME TO NORTHERN VIRGINIA DOCTORS OF OPTOMETRY

PATIENT FINANCIAL AND INSURANCE INFORMATION

PATIENT NAME:____ **GENDER: MALE / FEMALE**
(PLEASE PRINT) LAST NAME FIRST NAME MIDDLE INITIAL (PLEASE CIRCLE)

DATE OF BIRTH(MM/DD/YYYY)______/________/__________ **SOCIAL SECURITY NUMBER(last four):**___________

ADDRESS:____ **CITY**:________________________________

STATE:____________________________ **ZIP CODE**:______________________

HOME PHONE:(______)______-________ WORK PHONE:(_____)______-_________ CELL PHONE:(_____)_____-_________

E-MAIL ADDRESS:________________________________ **EMERGENCY CONTACT AND NUMBER:**______________________________

PERSON(S) WE CAN DISCUSS AND/OR RELEASE YOUR HEALTH INFORMATION TO: Self only___Name(s)_______________________

MAY WE LEAVE A VOICEMAIL/EMAIL ABOUT YOUR HEALTH INFORMATION: Yes______________ No______________

RACE (CHOOSE ONE): ___Asian ___Black ___White ___Native American ___Pacific Islander ___2 or more ___Other

ETHNICITY(CHOOSE ONE): ___Hispanic ___Not Hispanic

Employer:____ **Occupation:**____________________________________

******A NOTE TO ALL OUR CONTACT LENS WEARERS******

In most cases contact lenses are not considered "medically necessary" by insurance companies. Any test performed to determine or update a contact lens prescription **may not** be covered by insurance companies and will be the responsibility of the patient.

VISION INSURANCE
NAME OF INSURANCE:__________________________________**ID#**:_____________________________
SUBSCRIBER INFORMATION
NAME:______________________________**DATE OF BIRTH:**_____________________**SS# (last four):**_________
RELATIONSHIP TO PATIENT:__________________________ **WORK PHONE:(____)_____-_______**

PRIMARY MEDICAL INSURANCE
NAME OF INSURANCE:__________________________________**ID#**:_____________________________
SUBSCRIBER INFORMATION
NAME:______________________________**DATE OF BIRTH:**_____________________**SS# (last four):**_________
RELATIONSHIP TO PATIENT:__________________________ **WORK PHONE:(____)_____-_______**

SECONDARY MEDICAL INSURANCE
NAME OF INSURANCE:__________________________________**ID#:**_____________________________
SUBSCRIBER INFORMATION
NAME:______________________________**DATE OF BIRTH:**_____________________**SS# (last four):**_________
RELATIONSHIP TO PATIENT:__________________________ **WORK PHONE:(____)_____-_______**

Medical Release Authorization and Insurance Assignment:
I, the undersigned authorize payment from my insurance company to be made to Northern Virginia Doctors of Optometry (NVDO) for covered services. I understand that I am responsible for obtaining any referrals needed before my appointment or I must pay for that visit. Regardless of my insurances status, I am ultimately responsible for the balance on my account.

Should timely payments of this account not be made, I authorize NVDO to retain the services of an attorney and/or collection agency to assist with the collection of any outstanding balance. Any expenses incurred by such an action shall become an additional liability for which I am responsible. I certify that the information I have recorded with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information, to my insurance company in order to determine insurance benefits to which I may be entitled, this authorization may be revoked by myself at any time in writing.

I have reviewed a copy of Northern Virginia Doctors of Optometry notice of Privacy Policies

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PRINT NAME SIGNATURE DATE