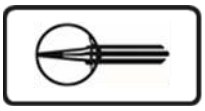
Tysons Corner
8150 Leesburg Pike, 909
Vienna, Virginia 22182
Phone: (703) 790-1780
Fax: (703) 734-0491



Fairfax/Merrifield
3020 Hamaker Court, 503
Fairfax, Virginia 22031
Phone: (703) 698-2020
Fax: (703) 698-7043

Welcome to Northern Virginia Center for Eye Care

PATIENT INFORMATION

Patient Name (Last, First, Middle Initial): _____

Address: _____ City: _____ State: _____ Zip: _____

Birthdate: _____ Age: _____ Sex: ☐ Male ☐ Female

Mobile: (_____)_____ Home: (_____)_____ Work: (_____)_____ Ext: _____

Email: _____

Occupation: _____ Employer/School: _____

Spouse's Name: _____

Mobile: (_____)_____ Home: (_____)_____ Work: (_____)_____ Ext: _____

Emergency Contact Name: _____ Relationship: _____

Mobile: (_____)_____ Home: (_____)_____ Work: (_____)_____ Ext: _____

Primary Care Physician:

Name (First, Last): _____
Phone: (_____)_____
Fax: (_____)_____
Address: _____
City: _____ State: _____ Zip: _____

Referring Physician:

Name (First, Last): _____
Phone: (_____)_____
Fax: (_____)_____
Address: _____
City: _____ State: _____ Zip: _____

Preferred Pharmacy:

Name: _____ Phone: _____ Fax: _____
Address: _____ City: _____ State: _____ Zip: _____

INSURANCE

Please check box if you do not have insurance ☐

PRIMARY INSURANCE: _____
Subscriber Name: _____
Birthdate: _____
Relationship to Patient: _____
ID Number: _____
Group Number: _____

SECONDARY INSURANCE: _____
Subscriber Name: _____
Birthdate: _____
Relationship to Patient: _____
ID Number: _____
Group Number: _____

Assignment and Release:

I certify that I, and/or my dependent(s), have insurance coverage and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian, or Personal Representative: _____

Printed Name of Above Signature: _____

Date: _____ **Relationship to Patient:** _____

EYE HEALTH HISTORY

Date of last eye exam? _____ Doctor: _____
Date of last dilated exam? _____ Doctor: _____
Do you wear glasses? Yes _____ No _____
Do you wear contact lenses? Yes _____ No _____ If yes, what type? _____
If No, have you worn them in the past? Yes _____ No _____

What is your current ocular complaint?

_____
_____
_____

List any Eye History:

_____
_____
_____

List any past ocular surgeries / procedures (please include date):

_____
_____

HEALTH HISTORY

Date of last physical exam? _____

List any Medical Conditions:

_____
_____
_____
_____

Pregnant? _____ Alcohol Use? _____ Tobacco Use? _____

List any past medical surgeries / procedures (please include date):

_____
_____
_____
_____

Medications:

_____
_____
_____
_____

Allergies:

_____
_____

I, _____ certify that the information added to this form is accurate.
Patient, Parent, Guardian, or Personal Representative

Signature: _____ Date: _____

Relationship to Patient: _____

Who may we thank for referring you to our practice? _____