Name:
DOB:
Chart:
Age:
Date:

Patient Information

Account # ______________

Patient Name ______________

Social Security Number

Home Telephone # ______________
Work Telephone # ______________
Cell Telephone # ______________

Address

Patient Sex

City, State & Zip code

Date of Birth ______________ **Age** ______________

FOR MEDICARE PATIENTS ONLY
Do you currently reside in a Skilled Nursing Facility?
☐ Yes ☐ No

Emergency Contact Name & Phone ______________

Relationship to Patient:

Are you currently under hospice care? ☐ Yes ☐ No

Employer name & Address ______________

Employment / Student Status:
☐ Full time employed ☐ Full time student
☐ Part time employed ☐ Part time student
☐ Unemployed ☐ Retired

Occupation: ______________

Pharmacy Name ______________
Pharmacy Phone ______________ **Fax**______________

Referring Physician: ______________

Family Physician:______________

Email Address (please print) ______________

Married ☐ **Single** ☐ **Other** ☐
Spouse's Name ______________

In compliance with the American Recovery and Reinvestment Act of 2009 (AARA) to demonstrate Meaningful Use, we are required to capture demographic data including your preferred language, race and ethnicity.

Patient Smoking Status:
☐ **Current Everyday Smoker** ☐ **Heavy Tobacco Smoker**
☐ **Current Someday Smoker** ☐ **Light Tobacco Smoker**
☐ **Smoker, current status Unknown**
☐ **Never Smoker** **Start Date:** ______________
☐ **Former smoker** **Quit Date:** ______________
☐ **Unknown if ever Smoker** **Packs per day:**______________

Ethnicity of Patient:
☐ Hispanic Origin
☐ Non Hispanic Origin
☐ Unknown
☐ Decline to answer

Race of Patient:
☐ **American Indian/Alaskan Native**
☐ **Asian**
☐ **Black/African American**
☐ **Native Hawaiian/Other Pacific Islander**
☐ **White**
☐ **Unknown**
☐ **Declined to answer**

Preferred Language of Patient:
☐ **English** ☐ **Spanish**
☐ **Other** ______________

Financially Responsible Person (if different from above)

Full Name ______________

Social Security Number ______________

Address ______________

Home Telephone # ______________

City, State & Zip Code ______________

Work Telephone # ______________

Date of Birth ______________

Cell Telephone # ______________

Employer Name ______________

Relationship to the Patient (check one)
☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Other

Date Reviewed ______________ Initials______________

Name:
DOB:
Chart:
Age:
Date:

Insurance Company Information

Primary Insurance Company Name		Secondary Insurance Company Name	
Address, City, State & Zip		Address, City, State, Zip	
Policy Holder	Date of Birth	Policy Holder	Date of Birth
Policy Holder Employer	Policy Holder SSN	Policy Holder Employer	Policy Holder SSN
Policy Number	Group Number	Policy Number	Group Number
Policy Holder Sex ☐ Male ☐ Female		Policy Holder Sex ☐ Male ☐ Female	
Relationship to the patient (check one) ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Other		Relationship to the patient (check one) ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Other	

Appointment Information:

Patient Name: ______________________ **Account #:** ______________

Name of Physician to see today: ______________________

Name of Physician who referred you here today: ______________________

Insurance Authorization and Assignment of Benefits

I certify that the information that I have reported with regards to my insurance coverage is correct. I also authorize the release of any medical information necessary to process this claim. I also authorize payment of medical benefits to Eye Consultants of Northern Virginia, PC for medical and surgical services provided to me. I fully understand that payment for services is not contingent upon recovery and this does not relieve me of my primary obligation to pay.

Signature ______________________ **Date** ______________________

Medicare Patients

If you are covered by Medicare, please read and sign the following:
In Medicare cases, Eye Consultants of Northern Virginia, PC, agrees to accept the charge determination of Medicare as the full charge, and the patient is responsible only for deductible, coinsurance and non-covered services. Coinsurance and the deductibles are based upon the charge determination of Medicare.

Signature ______________________ **Date** ______________________