Eye Specialists & Surgeons
OF NORTHERN VIRGINIA

PATIENT REGISTRATION INFORMATION

Date:_____Date of Birth:_____Age:_____SSN:_____-_____-___

Last Name:_____First Name:_____Middle Initial:_____Gender: ☐ Male ☐ Female

Optional: Race/ Ethnicity_____ Language(s) Preferred:_____

Address:_____Apt#:_____City:_____

State:_____Zip Code:_____Home Phone:_____Cell Phone: _____

Email:_____(EMAIL AND PHONE ARE REQUIRED)

Marital Status (circle one): Single/Married/Div./Sep./Widowed Spouse's Name (if applicable): _____

Primary Care Physician:_____Phone:_____

Address:_____

Pharmacy Address:_____Phone:_____

Referred by: _____

In case of emergency, who should we contact?_____Phone: _____
Relationship to Patient:_____

☐ **WORKMAN'S COMPENSATION CARRIER**:_____ Adjuster Name:_____

Address: _____ Phone:_____Claim #_____ DOI: _____

PRIMARY MEDICAL INSURANCE:

Person responsible for account:_____Phone:_____

Relationship to Patient:_____Date of Birth: _____

Address (if different from patient): _____

Ins. Company:_____Ins. Company Address: _____

Subscriber ID#:_____Group #:_____Co-pay: $_____

SECONDARY MEDICAL INSURANCE:

Person responsible for account:_____Phone:_____

Relationship to Patient:_____Date of Birth: _____

Address (if different from patient): _____

Ins. Company:_____Ins. Company Address: _____

Subscriber ID#:_____Group #:_____Co-pay: $_____

VISION INSURANCE:

Insurance Company: _____ Person responsible for account:_____

Subscriber SSN#: _____ Subscriber ID#:_____

Relationship to Patient: _____ Date of Birth: _____

Address (if different from patient): _____

Employer Name: _____ Employer Telephone: _____

Signature of Responsible Party: _____ **Date:** _____

MEDICAL INFORMATION SHEET **NAME:** _____

Chief Complaint: What is the main or primary problem with your eye(s), and when did you first notice symptoms or were you told of diagnosis?

_____

_____

_____

_____

EYE History (Please circle all that apply) or circle NONE

Glaucoma	Cataract	Lazy Eye (Amblyopia)
Crossed Eyes (Strabismus)		Macular Degeneration
Retinal Detachment	Eye Injury	Eye Inflammation
Laser Surgery	Operative Surgery	Other:_____

GENERAL HEALTH (Please circle all that apply) or circle NONE

Fevers Weight Loss	Fatigue	
Sinusitis / Nasal Allergies	Hearing Loss	Dry Mouth
Angina / Chest Pain	Heart Attack	Congestive Heart Disease
Rheumatic Heart Disease	Heart Murmur	Irregular or Slow Heartbeat
High Blood Pressure	Stroke	
Shortness of Breath Asthma	Bronchitis	Emphysema
Heartburn / Ulcer Hepatitis	Diabetes	
Liver Disease	Kidney Disease	Kidney Stones

Other: _____

PAST MEDICAL HISTORY:

_____
_____
_____
_____
_____
_____

SURGICAL HISTORY:

_____
_____
_____
_____

Smoking History:
Do you Smoke: Yes No
If Yes: Are you trying to quit?
Yes No
If No: Are you a former smoker?
Yes No

FAMILY HISTORY (GENERAL OR EYE):

_____
_____
_____
_____
_____

Medications (Names/dosage):

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Allergies to Medications (Name/reaction):

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Please Answer if age >65
Influenza vaccine: Yes No
Pneumococcal vaccine: Yes No
Shingles vaccine: Yes No

Patient Signature: _____ **Date:** _____

Doctor's Signature: _____ **Date:** _____

Do you want anyone to have access to your medical record?

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to Privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessment and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this practice has the right to change this notice from time to time, and that I may contact the practice at any time to obtain a current copy.

I understand that I may request in writing that yourestrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

The type of PHI to be restricted or limited:

_____

I give permission to discuss my medical care with the following individuals:

_____

I understand that I may revoke this consent at any time, except to the extent that you have to take action relying on this consent.

Refraction & Contact lens fitting Fee Policy (MEDICAL PLANS)

What is a refraction?

Refraction is a test done to determine the refractive error of your eyes, or the need for corrective glasses and/or contact lenses. i.e. A Glasses prescription.

When do I have to pay for a refraction?

Refraction (CPT code 92015) is a non-covered service by Medicare.

As a result, your healthcare provider is required by CMS (the department to the federal government that controls Medicare) to charge for this service. Most other insurance plans follow Medicare's rules. All these plans consider refraction a "vision" service not a "medical" service. If you have a separate vision plan please let us know.

How much do I have to pay?

You will only be charged a refraction fee if you receive a prescription for glasses or contact lenses. **Our office fee for refraction is $50. Contact lens fitting costs vary.** This is collected at the time of service in addition to any copayment your plan may require.

Patient's Name: _____

Signature of Patient: _____

Relationship to Patient: _____

Date: _____