

NORTHERN VIRGINIA OPHTHALMOLOGY ASSOCIATES
PATIENT REGISTRATION FORM

Title (Mr., Ms., Etc...) First Name Middle Name Last name Suffix

Date of Birth Age Sex
 Hispanic / Latino
 Non-Hispanic / Non-Latino
 Other I decline to answer

Race Ethnicity Language Decline to Answer

Street Address Apt # City State Zip Code
 Mobile Staff can leave detailed messages

Home/Primary Phone Number (and contact name and relationship for minor patients)
 Mobile Staff can leave detailed messages

Work/Secondary Phone Number (and contact name and relationship for minor patients)

Email Address (and contact name and relationship for minor patients)

Preferred method of communication (please select one option)
We will use this method to contact you **first**, but may use other contact methods (call, email, mail, etc.) if we are unable to reach you. To update this method, you can contact our office. If no method is selected, we will call you on your primary phone number first.
 Yes No Yes No N/A (I am registered)

Are you registered for our Patient Portal? If not, do you want to register for our Patient Portal?

Primary Care Physician or Primary Care Group PCP Location (City & State) PCP Phone Number
(required for patients with HMO insurance and minor patients)

Referring Provider Name or Group Phone Number

Emergency Contact Name Relationship Phone Number

Employer Name (or current occupation of parent(s) for minor patients)

PRIMARY INSURANCE:
Name of Policyholder:
Policyholder's Date of Birth: Relationship to Patient (Please circle one): SELF | CHILD | SPOUSE | OTHER

SECONDARY INSURANCE:
Name of Policyholder:
Policyholder's Date of Birth: Relationship to Patient (Please circle one): SELF | CHILD | SPOUSE | OTHER

In order to verify Routine Eye Coverage through VSP, please provide the policyholder's last 4 digits of SSN: _____

NVOA ONLY takes Vision Service Plan (VSP) for *vision insurance*. Do you have VSP for your ROUTINE VISION CARE? YES NO
Name of Policyholder:
Policyholder's Date of Birth: Relationship to Patient (Please circle one): SELF | CHILD | SPOUSE | OTHER
Policyholder's last 4 digits of SSN _____