Patient Registration Form

Patient Information

Name: ☐ Mr. ☐ Ms. ☐ Mrs. ☐ Other
First: _____ Middle: _____ Last: _____ Suffix: _____

Date of Birth: _____ Age: _____ Gender: ☐ Male ☐ Female

Ethnicity: ☐ Hispanic / Latino ☐ Non-Hispanic / Non-Latino ☐ Other ☐ Prefer not to answer
Race: _____ Preferred Language: _____

Address: _____ Apt #: _____
City: _____ State: _____ Zip Code: _____

Phone Numbers:

- Home: _____ ☐ Staff may leave detailed messages
- Mobile: _____ ☐ Staff may leave detailed messages
- Work/Secondary: _____ ☐ Staff may leave detailed messages

Email Address: _____
Preferred Method of Contact: ☐ Phone ☐ Email ☐ Mail

Patient Portal Registration

Are you registered for our Patient Portal? ☐ Yes ☐ No If not, would you like to register? ☐ Yes ☐ No

Primary Care Provider: Name/Practice: _____ Phone: _____

Referring Provider (if applicable): _____ Phone: _____

ER Contact: Name: _____ Relationship: _____ Phone: _____

Employment: Employer / Occupation: _____ (For minor patients, list parent(s) occupation)

Insurance Information

Primary Insurance

Insurance Company: _____ Policyholder Name: _____
Policyholder DOB: _____ Relationship to Patient: ☐ Self ☐ Child ☐ Spouse ☐ Other

Secondary Insurance

Insurance Company: _____ Policyholder Name: _____
Policyholder DOB: _____ Relationship to Patient: ☐ Self ☐ Child ☐ Spouse ☐ Other

Vision Insurance (We ONLY accept VSP at NVOA)

Do you have VSP (Vision Service Plan) for routine vision care? ☐ Yes ☐ No
Policyholder Name: _____ Policyholder DOB: _____
Relationship to Patient: ☐ Self ☐ Child ☐ Spouse ☐ Other Last 4 digits of SSN: _____