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 insuranse 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 _____