



WELCOME TO NORTHERN VIRGINIA DOCTORS OF OPTOMETRY

PATIENT FINANCIAL AND INSURANCE INFORMATION

PATIENT NAME: TODAY'S DATE:
IF MINOR, PARENT'S NAME: SEX: M F SS #
ADDRESS DATE OF BIRTH
HOME #:
E-MAIL ADDRESS: WORK #:
EMPLOYER: OCCUPATION:
EMERGENCY CONTACT: PHONE #:

Updated in Computer _____ initials

***** A NOTE TO ALL OUR CONTACT LENS WEARERS *****

In most cases contact lenses are not considered "medically necessary" by insurance companies. Any tests performed to determine or update a contact lens prescription may not be covered by most insurances companies and will be the responsibility of the patient.

If not using insurance today, please list the person financially responsible for this account:

VISION INSURANCE: Please complete if using insurance today:

PRIMARY INSURANCE: SOCIAL SECURITY NUMBER:
ADDRESS: ID #:
PHONE # GROUP #:

SECONDARY INSURANCE: ID #:
ADDRESS: GROUP #:

PRIMARY MEDICAL INSURANCE: In order to insure a comprehensive ocular health examination, certain procedures (such as dilation, photographs, visual fields etc.) may be required, but may not be covered under your vision insurance. However, these procedures may be covered under you medical insurance if it is medically necessary:

Name: Social Security Number:
Address: ID #:
PHONE # Group #:

Medical Release Authorization and Insurance Assignment:

I, the undersigned authorize payment from my insurance company to be made to Northern Virginia Doctors of Optometry (NVDO) for covered services. I understand that I am responsible for obtaining any referrals needed before my appointment or I must pay for that visit. Regardless of my insurances status, I am ultimately responsible for the balance on my account.

Should timely payments of this account not be made, I authorize NVDO to retain the services of an attorney and/or collection agency to assist with the collection of any outstanding balance. Any expenses incurred by such an action shall become an additional liability for which I am responsible.

I certify that the information I have recorded with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information, to my insurance company in order to determine insurance benefits to which I may be entitled, this authorization may be revoked by myself at any time in writing.

Print Name Signature Date