VIRGINIA OPHTHALMOLOGY ASSOCIATES

885 KEMPSVILLE ROAD, SUITE 101, NORFOLK, VIRGINIA 23502 • (757) 461-1444

PATIENT INFORMATION

Name _____ Social Security No. _____

Address _____ City _____ State _____ Zip Code _____

Home Phone (_____) _____ Work Phone (_____) _____ Cell Phone (_____) _____

Date of Birth _____ Age _____ Sex _____ Marital Status Single Married Widowed Divorced

Are You Currently Employed? (YES NO) Employer _____

Who Were You Referred By _____

Primary Care Physician _____ Phone Number _____

SPOUSE INFORMATION:

Name _____ Social Security No. _____

Date of Birth _____ Work Phone (_____) _____ Cell Phone (_____) _____

Spouse currently employed? (YES NO) Employer _____

IN CASE OF EMERGENCY, PLEASE CONTACT:

Name _____

Home Phone (_____) _____ Work Phone (_____) _____ Cell Phone (_____) _____

Relationship to Patient _____

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IF PATIENT IS A MINOR: (UNDER 18)

PLEASE PRINT

Who is legally responsible for the child _____

Are you a parent or legal guardian (please circle)

PARENTAL INFORMATION

Mother's Name _____ Mother's Social Security # _____

Mother's Address (if different than child) _____

City _____ State _____ Zip Code _____

Home Phone (_____) _____ Work Phone (_____) _____ Cell Phone (_____) _____

Mother currently employed: YES NO Date of Birth _____

Employer _____

Father's Name _____ Father's Social Security # _____

Father's Address (if different than child) _____

City _____ State _____ Zip Code _____

Home Phone (_____) _____ Work Phone (_____) _____ Cell Phone (_____) _____

Father currently employed: YES NO Date of Birth _____

Employer _____

IF LEGAL GUARDIAN, please fill out this section:

Legal Guardian Name _____ Social Security # _____

Address (if different than child) _____

City _____ State _____ Zip Code _____

Home Phone (_____) _____ Work Phone (_____) _____ Cell Phone (_____) _____

Guardian currently employed: YES NO Date of Birth _____

Employer _____

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INSURANCE INFORMATION

PLEASE PRINT

Primary Insurance_____ Insurance ID Number_____

Primary Insured Name_____ Date of Birth_____

Secondary Insurance_____ Insurance ID Number_____

Secondary Insured Name_____ Date of Birth_____

Third Insurance_____ Insurance ID Number_____

WORKER'S COMPENSATION:

Is this a work-related injury?_____ If Yes, please provide:

Date of Injury_____ Phone Number_____

Employer_____ Name of Contact_____

Employer Address_____ City_____ State_____ Zip_____

PATIENT RESPONSIBILITY - Please read and initial for acceptance of each statement.

_____ All patients are responsible for deductibles, copays and coinsurance at the time of visit unless indicated otherwise.

_____ **Refractions are a non-covered service with most insurance companies. This charge is the patient's responsibility.**

_____ I authorize my medical information to be released to the above insurance company, and to file my insurance for all dates of service.

_____ I authorize payment to be made to Virginia Ophthalmology Associates.

_____ I understand that I am responsible for any fees incurred for my treatment by Virginia Ophthalmology Associates and agree to pay collection and attorney fees if necessary.

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ROUTINE VISION STATEMENT

It is important that you understand that your vision plan (Vision Service Plan & Superior Vision) covers ROUTINE eye care only (nearsightedness, farsightedness and normal astigmatism). Our doctors at Virginia Ophthalmology Associates are committed to giving you the highest quality of eye care. During your exam, our physicians will examine you for any medical conditions. If your eye exam involves a medical condition related to your eyes that requires specific counseling, documentation, follow-up care, regular monitoring or referral to one of our surgeons, then your visit is no longer a ROUTINE eye exam and is NOT COVERED by your vision plan. Your medical insurance will be filed and the terms of that policy will apply to your visit. If you have further questions our staff is happy to assist you.

ACCEPTED VISION PLANS:
Vision Service Plan (VSP)
Superior Vision

Date

Patient, Parent's or Guardian's Signature