VIRGINIA
OPHTHALMOLOGY
ASSOCIATES

885 Kempsville Rd., Suite #101, Norfolk, VA 23502. p. 757-461-1444, f. 757-461-8238. www.voaeye.com

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 sign below for acceptance of each statement.

- 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.

_____ _____

Patient, parent or Guardian's Signature Date