Norfolk Eye Physicians & Surgeons Limited

____ 1005 May Avenue
Norfolk, VA 23504
Phone: 757-623-2123

____ 828 Healthy Way, Suite 370
Virginia Beach, VA 23462
Phone: 757-474-7420

Patient Registration Form

(Please print and complete ALL questions. Please Hand Insurance Cards and Picture ID to Receptionist to Scan)

Patient Name with M.I.: _____Sex: ____F ___M

Social Security#:_____Date of Birth_____

Home Phone: (_____)_____ Cell Phone: (_____)_____ Cell Phone Provider: _____

Work Phone: (_____)_____ Ext: _____ Email Address: _____ No Email: ____

Home Address: _____City: _____ State: _____ Zip: _____

Marital Status: Single: ____ Married: ___ Divorced: ____ Widowed: ____ Separated: ____ Birth State: _____
Mother's Maiden Name: _____
Race (Government Required): American Indian/Alaskan Native: ____ Asian/Pacific Islander: ____ Hispanic: ____
African American (non-Hispanic): ___ Caucasian (non-Hispanic): ____ Primary Language: _____

Employer: _____ Position Held: _____

Employer Address: _____City: _____ State: _____ Zip: _____

Insurances: 1. Primary: _____ Member ID#: _____Group#_____

2. Secondary: _____ Member ID#: _____Group#_____

3. Vision Plan: _____Member ID#: _____Group#_____

Emergency Contact Information:
Name: _____ Relationship To Patient: _____
Contact's Address: _____City: _____ State: _____ Zip: _____
Home Phone: _____Cell Phone: _____ Work Phone: _____

******Please sign and date below******

ASSIGNMENT OF BENEFITS/MEDICARE AUTHORIZATION FOR TREATMENTS:

I hereby authorize treatment; and I request that payment of authorized Medicare benefits or other Insurance benefits be made either to me or on my behalf to Norfolk Eye Physicians & Surgeons, LTD and its' subdivisions for any services furnished me by their physicians. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its' agents or my insurance carrier any information needed to determine these benefits or the benefits payable for related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on the approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the Insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of Medicare carrier as the charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of Medicare carrier.

Patient: _____ Date: _____