



EYE CONSULTANTS OF NORTHERN VIRGINIA, P.C.

REFERRED BY: _____ FAMILY DOCTOR: _____

Mr. Mrs. Miss Ms. _____ Today's Date _____
Last First Middle

Home Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____

E-mail address _____ Marital Status Single Married Divorced Widowed

Social Security Number _____ Date of Birth _____ Age _____ Gender M F

Employer/Parent's employer _____ Occupation _____

Work Address _____ Work Phone _____

City _____ State _____ Zip Code _____

Spouse name(Parent name if minor) _____ Spouse/Parent Work Phone _____

Person to notify in case of emergency (other than spouse) _____

Phone number(s) _____ Relationship _____

Primary Insurance Company Name and Address		
ID#	Group #	Effective Date
Subscriber Name		Relationship to Patient
Social Security Number	Date of Birth	Employer

Secondary Insurance Company Name and Address		
ID#	Group #	Effective Date
Subscriber Name		Relationship to Patient
Social Security Number	Date of Birth	Employer

I certify that I (or my dependent) have insurance coverage as stated above and agree to have insurance payments made directly to Eye Consultants of Northern Virginia, P.C. (Drs.Goldberg/Parelhoff/Gadol/) to be applied to my account for services rendered. I understand that I am financially responsible for all charges incurred in the event that my insurance denies payment. For patients covered by Medicare the patient will be responsible for 20% of the Medicare allowable charges plus any deductibles, coinsurance and uncovered charges that apply.

Patient's Signature

Today's Date