I acknowledge receipt of Eye Specialists of Virginia's Notice of Privacy Practices

____
Signature Date

Wesley Mullen, M.D.
Anne H. McElroy, M.D.
Christopher R. McGarry, O.D.
Eye Specialists of Virginia

PATIENT INFORMATION

NAME____ DATE__________________
LAST FIRST MIDDLE

ADDRESS____
NO. & STREET CITY STATE ZIP

PHONE____________________AGE______SEX______DATE OF BIRTH____________________
MO/DAY/YEAR

MARITAL STATUS: MARRIED ☐ SINGLE ☐ WIDOWED ☐ DIVORCED ☐

SPOUSE or NEAREST RELATIVE____

MEDICAL DR____________________________REFERRED BY__________________________

OCCUPATION____________________________SOCIAL SECURITY #____________________

EMPLOYER____
PHONE # or ADDRESS

NAME OF INSURANCE CO.________________________VISION PLAN____________________

PRIMARY INSURED____
NAME DATE OF BIRTH LAST 4 DIGITS OF SOCIAL SECURITY #

WERE YOU INJURED ON THE JOB?_____HOW and WHEN_________________________________

____
EMPLOYER NAME/PHONE/ADDRESS

DO YOU HAVE ALLERGIES TO ANY MEDICATIONS?_____________________________________

____

LIST ANY MEDICATIONS YOU TAKE REGULARLY:_____________________________________

____

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PLEASE READ:

We appreciate payment for services when rendered as this helps defray costs. We will file your insurance and/or medicare for you. Rarely does insurance or medicare cover all office fees.

AUTHORIZED TO RELEASE INFORMATION AND TO PAY INSURANCE BENEFITS:
I hereby authorize the above named physician to release the information requested to the insurance company named hereon. Also by my signature and copies thereof, I authorize payment directly to the above named physicians of benefits otherwise payable to me. I understand that I am financially responsible for charges not covered by this authorization and for fees charged by collection agencies should they be required for collection of this account.

SIGNED____DATE:__________________

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