

**PRINCE WILLIAM
EYE ASSOCIATES, PLLC**

8912 CENTREVILLE RD MANASSAS, VA 20110
PHONE 703-361-6151 FAX 703-361-1750

PATIENT NAME:			EMERGENCY CONTACT:	RELATION:
STREET ADDRESS:		APT#	EMERGENCY CONTACT'S PHONE:	
CITY	STATE	ZIP CODE	PRIMARY PHYSICIAN:	
IF MINOR, PARENT/GUARDIAN'S NAME:			PRIMARY PHYSICIAN'S PHONE:	
SEX: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE			WHO WERE YOU REFERRED BY?	
MARITAL STATUS: <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED				
HOME PHONE:			EMPLOYMENT: <input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME <input type="checkbox"/> NOT EMPLOYED <input type="checkbox"/> RETIRED	
CELL PHONE:			EMPLOYER:	
DATE OF BIRTH:		AGE:	POSITION:	
SOCIAL SECURITY NUMBER:			EMPLOYER'S PHONE:	

VISION INSURANCE

SELECT ONE: VSP EYEMED SPECTERA SUPERIOR AVESIS OTHER _____

PRIMARY INSURED:	PRIMARY'S SOCIAL SECURITY NUMBER:
RELATION TO PATIENT:	PRIMARY'S DATE OF BIRTH:

PRIMARY MEDICAL INSURANCE

INSURANCE:	
PRIMARY INSURED:	PRIMARY'S SOCIAL SECURITY NUMBER:
RELATION TO PATIENT:	PRIMARY'S DATE OF BIRTH:

SECONDARY MEDICAL INSURANCE

INSURANCE:	
PRIMARY INSURED:	PRIMARY'S SOCIAL SECURITY NUMBER:
RELATION TO PATIENT:	PRIMARY'S DATE OF BIRTH:

OUR DOCTORS MAY SUGGEST MEDICAL TESTING TO DIAGNOSE AND/OR TREAT ANY MEDICAL CONDITIONS THAT MAY BE PRESENT. OUR OFFICE WILL SUBMIT TO YOUR MEDICAL INSURANCE AS A COURTESY ON YOUR BEHALF. COPAYS ARE DUE AT THE TIME OF SERVICE. YOU WILL BE RESPONSIBLE FOR ANY UNAPPLIED DEDUCTIBLE OR BALANCE TRANSFERRED FROM YOUR INSURANCE COMPANY AFTER THE CLAIM HAS BEEN REVIEWED AND PAID ACCORDINGLY. YOU ARE RESPONSIBLE FOR BEING AWARE OF ALL COVERAGE AND DEDUCTIBLE INFORMATION BEFORE THE SERVICES ARE RENDERED. IF YOU ARE UNSURE OF YOUR COVERAGE, PLEASE CONTACT YOUR INSURANCE COMPANY IMMEDIATELY.

IF YOU ARE BEING SEEN FOR A MEDICAL REASON AND/OR DO NOT HAVE ROUTINE VISION COVERAGE, YOU ARE RESPONSIBLE FOR THE REFRACTION FEE OF \$35.00 IN CONJUNCTION WITH YOUR SPECIALIST COPAY. THE REFRACTION IS NOT COVERED BY YOUR MEDICAL INSURANCE AND IS CONSIDERED ROUTINE. IT IS NECESSARY TO PERFORM THIS SERVICE TO DETERMINE YOUR PRESCRIPTION ONCE A YEAR.

CONTACT LENS PATIENTS:

A CONTACT LENS FITTING IS REQUIRED YEARLY TO OBTAIN A VALID CONTACT LENS PRESCRIPTION. CONTACT LENSES ARE NOT CONSIDERED MEDICALLY NECESSARY, THEREFORE YOUR INSURANCE MAY NOT COVER YOUR FITTING. THE FITTING FEE IS AN ADDITIONAL CHARGE TO YOUR ROUTINE EYE EXAM DUE AT THE TIME OF SERVICE WITH YOUR COPAY. CONTACT LENS PRESCRIPTIONS EXPIRE ONE (1) CALENDAR YEAR AFTER THE ORIGINAL EXAM DATE.

PERMISSION TO PROVIDE TREATMENT AND/OR RECORD RELEASE IF NECESSARY:

I AUTHORIZE PAYMENT FROM MEDICARE AND/OR ANY OTHER INSURANCE COMPANIES TO BE MADE ON MY BEHALF TO PRINCE WILLIAM EYE ASSOCIATES, PLLC FOR ANY SERVICES FURNISHED BY THE PHYSICIAN OR SUPPLIER. I AUTHORIZE PRINCE WILLIAM EYE ASSOCIATES, PLLC TO RELEASE ANY INFORMATION NECESSARY TO DETERMINE MY ELIGIBILITY OF BENEFITS PAYABLE AT THE TIME OF SERVICE TO THE HEALTH CARE FINANCING ADMINISTRATION (INSURANCE COMPANY) AND ITS AGENTS.

PLEASE SIGN & DATE BELOW THAT YOU HAVE FILLED OUT THIS FORM TO THE BEST OF YOUR KNOWLEDGE AND HAVE READ THE ABOVE STATEMENTS:

PATIENT SIGNATURE OR PARENT / LEGAL GUARDIAN'S SIGNATURE:	DATE:
X	

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LIST ALL CURRENT MEDICATIONS (PRESCRIPTION AND OVER THE COUNTER)

1	5
2	6
3	7
4	8

LIST ALL ALLERGIES TO ANY MEDICATIONS

MEDICATION	ALLERGIC REACTION / SYMPTOMS
1	1
2	2
3	3
4	4

DO YOU SMOKE? YES NO IF YES, HOW OFTEN? _____

HAVE YOU EVER HAD A BLOOD TRANSFUSION? YES NO IF YES, WHAT YEAR? _____

ILLNESS (PAST / PRESENT)	SELF		DURATION	FAMILY HISTORY		RELATION
	YES	NO		YES	NO	
GLAUCOMA						
ARTHRITIS						
CANCER						
HEART DISEASE						
HIGH BLOOD PRESSURE						
KIDNEY DISEASE						
STROKE						
THYROID DISEASE						
ASTHMA / EMPHYSEMA						
AIDS / HIV						
DIABETES TYPE I / TYPE II						
OTHER:						

LIST ANY **EYE SURGERY** YOU HAVE HAD (CATARACT, CORNEAL TRANSPLANT, ETC.)

LIST ANY **SURGERIES** YOU HAVE HAD (APPENDECTOMY, TONSILLECTOMY, ETC.)

PLEASE SIGN & DATE BELOW THAT YOU HAVE FILLED OUT THIS FORM TO THE BEST OF YOUR KNOWLEDGE:

PATIENT SIGNATURE OR PARENT / LEGAL GUARDIAN'S SIGNATURE: X	DATE:
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DOCTOR'S SIGNATURE (PROOF OF MEDICAL HISTORY REVIEW)

DATE:

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I give Prince William Eye Associates, PLLC my consent to use and/or disclose the minimum amount of protected health information to carry out any treatment necessary, payment from insurance companies for services rendered and for health care operations such as quality reviews.

I have been informed that I may review Prince William Eye Associates, PLLC's Notice of Privacy Practices, which is clearly posted, for a more complete description of uses and/or disclosures before signing this consent.

I understand that Prince William Eye Associates, PLLC has the right to change/revise their privacy practices and that I may obtain any revised notices.

I also understand that I may revoke this consent at any time by making a request in writing.

PATIENT SIGNATURE OR PARENT / LEGAL GUARDIAN'S SIGNATURE:

DATE:

X