

Eye Physicians of Virginia, Ltd.

Kenneth M. Karlin, M.D. A. Catherine Schwartz, M.D. Brian M. Egan, M.D.

6845 Elm Street • Suite 611 • McLean, Va. 22101-3822 • Tel: (703)365-6880 • Fax: (703)893-7336

1800 Town Center Drive • Suite 317 • Reston, Va. 20190-3239 • Tel:(703)437-3900 • Fax: (703)437-9426

Patient Registration Form

First Name: _____ MI: ____ Last Name: _____
Social Security #: _____ - _____ - _____ Sex: M F Date of Birth: ____/____/____ Age: ____
Marital Status: Single Married Divorced Widowed
Street Address: _____ City: _____ State: ____ Zip: _____
Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____ Occupation: _____
Cell Phone: (____) _____ - _____ E-Mail Address: _____
Employment Status: Full Part Retired Employer: _____
Student Status: Full Part Name of School: _____
Emergency Contact's Name: _____ Phone Number: (____) _____ - _____
Referring Physician: _____ Phone Number: (____) _____ - _____

Billing Information

First Name: _____ Last Name: _____ Relationship to Patient: _____
Street Address: _____ City: _____ State: ____ Zip: _____
Employer: _____ Work Phone: (____) _____ - _____ Home Phone: (____) _____ - _____

Insurance Information

Primary Ins. Holder of Policy: Self Spouse Parent
Primary Ins. Co: _____ ID #: _____ Group: _____
First Name: _____ MI: ____ Last Name: _____ SS #: _____ - _____ - _____
Sex: M F Date of Birth: ____/____/____ Age: _____
Street Address: _____ City: _____ State: ____ Zip: _____
Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____

Secondary Ins. Holder of Policy: Self Spouse Parent
Secondary Ins. Co: _____ ID #: _____ Group: _____
First Name: _____ MI: ____ Last Name: _____ SS #: _____ - _____ - _____
Sex: M F Date of Birth: ____/____/____ Age: _____
Street Address: _____ City: _____ State: ____ Zip: _____
Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____

Assignment and Release

I hereby authorize release of any information obtained in the course of my registration, interview, examination, and treatment, necessary to file a claim with my insurance carrier(s). Furthermore, I authorize payment directly to the physician(s) of any medical/ surgical benefits otherwise payable to me for services as described. I acknowledge personal responsibility for any monies not paid by my insurance carrier except that which is limited by contractual agreement between the physician and the insurer. If I have any desire to examine at my medical record, or specifically restrict who may access my medical record, or wish to file a Privacy complaint I agree to contact Debbie Karlin at (703) 356-6880. I recognize that payment for all co-pays and pre-determined out of pocket expenses are **due in full at time of service**. I acknowledge that it is my responsibility to know the amount of my co-pay/ deductible and agree to check with my insurance carrier to confirm any increases. I understand that if my account has not been paid in full after (60) sixty days from the date of my insurance carrier has made its final decision finance charges at a rate of 1.5% per month will be applied on my balance(s). In the event that my account is placed in the hands of a collection agency or attorney for collection, I agree to pay all costs and expenses related to the collection thereof. A copy of my signature consenting to this agreement is as valid as the original, and shall continue to be valid for one year from the date of signature.

Patient/Responsible Party's Signature

Date

Account Number

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Accident or Injury Information

Is Current Problem Due to an Accident or Injury? NO YES Date of Onset: ____/____/____

Referred By: _____ Phone #: (____) _____ - _____ Family Physician: _____

X-Rays Taken For This Problem? NO YES Date: ____/____/____ Location: _____

FEMALES ONLY!!!!!! POSSIBLE PREGNANCY NOW? NO YES

Present Medications: _____

If Emergency Treatment Rendered, Where and When? _____

Have You Missed Time From Work? NO YES If So, Give Dates: _____

IF DUE TO WORKER'S COMPENSATION OR ACCIDENT FILL OUT INFORMATION BELOW

FOR WORK RELATED INJURIES:

Compensation Insurance Carrier: _____ Claim Number: _____

Employer at time of Accident/ Address: _____

_____ Date of Injury: ____/____/____

Was Injury Reported to Supervisor? NO YES Name of Supervisor: _____ Phone: _____

Description of Injury: _____

Attorney's Name and Address (If Applicable): _____

_____ Phone: _____

FOR AUTO OR PERSONAL INJURY:

Date of Accident: ____/____/____ Location/Description of Accident: _____

Your Auto Ins. Co. Name: _____ Address: _____

Policy/Claim #: _____

Other Ins. Co. Name: _____ Address: _____

Policy/Claim #: _____

Attorney's Name (If Applicable): _____ Phone Number: _____

Address: _____