Virginia Retina Consultants **PLEASE PRINT**
Jacob C. Meyer, MD
Mohit Nanda, MD

PATIENT INFORMATION

NAME: _____ **DATE:** _____
LAST **FIRST** **MI**

ADDRESS: _____

CITY, STATE, ZIP: _____

DATE OF BIRTH: _____ **AGE** _____ **GENDER: M F**

PHONES - HOME ( ) _____ **CELL** _____ **WORK** _____

SOCIAL SECURITY NO. _____
(Note: If the social security number is not completed, you may be required to pay for today's visit in full.)

EMAIL ADDRESS: _____

EMPLOYER NAME AND ADDRESS: _____

SPOUSE'S NAME: _____ **SPOUSE'S WORK NO.** _____

SPOUSE'S EMPLOYER:_____

WHOM MAY WE THANK FOR YOUR REFERRAL TO OUR OFFICE? _____

PRIMARY CARE PHYSICIAN/FAMILY DOCTOR NAME _____

OPHTHALMOLOGIST AND/OR OPTOMETRIST NAME _____
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INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: _____CARD COPIED: Y N
If the patient is not the policy holder, what is the name and date of birth of the policy holder?

SECONDARY INSURANCE COMPANY: _____ CARD COPIED: Y N

DATE OF INSURANCE CHANGE: PRIMARY INSURANCE _____
_____
SECONDARY INSURANCE _____

DATE OF INSURANCE CHANGE: PRIMARY INSURANCE _____
_____
SECONDARY INSURANCE _____

NEAREST RELATIVE TO NOTIFY IN CASE OF EMERGENCY
(OTHER THAN SPOUSE)

NAME: _____ RELATIONSHIP:_____

ADDRESS: _____

PHONE NUMBERS: HOME _____ WORK: _____

EMPLOYER: _____

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CONSENT TO TREATMENT AND
RESPONSIBLE PARTY STATEMENT

I consent to examination and treatment of my eye condition by Virginia Retina Consultants.

I authorize Virginia Retina Consultants to furnish information to my insurance carrier(s) concerning my condition and/or treatments.

I assign all payments to Virginia Retina Consultants for medical services rendered to myself or my dependent at this facility. I understand that I am responsible for any amount not covered by insurance.

_____ _____
SIGNATURE OF PATIENT DATE

OR

_____ _____
SIGNATURE OF PATIENT'S REPRESENTATIVE DATE

MINORS: Nonemergency treatment will be denied for unaccompanied minors.