NVISION EYE CENTERS

Patient Information Form

+1(877)91-NVISION
+1(877)916-8474
www.NVISIONCenters.com

Last Name: _____ **First Name:** _____ **M.I.:** _____

DOB: _____ **Age:**_____ **SSN:** _____ **Sex:** ☐ Male ☐ Female ☐ Undifferentiated ☐ Decline to Specify

Address: _____

City: _____ **State:** _____ **Zip:** _____

***Phone Numbers:** Home ☐:_____ Work ☐:_____ Cell ☐:_____

** Check box next to phone number(s) where we may leave a message*

E-mail Address: _____

Employer Name: _____ **Occupation:** _____

How were you referred to NVISION Eye Centers?

☐ Doctor Referral: ☐ Family/Friend/Past Patient – Did they have refractive surgery with us? ☐ Yes ☐ No

_____ _____

** First & Last Name* ** Name & Relationship*

☐ Internet ☐ Drive-by ☐ Benefits Provider ☐ Other:

☐ Health/Workplace Event ☐ Newspaper/Magazine/Advertisement ☐ Radio _____

Which of the following above influenced you the most to schedule an appointment with us? _____

Primary Physician (Full Name)**:** _____ **Phone:** _____ **City:** _____

Optometrist (Full Name)**:** _____ **Office** (Name)**:** _____ **City:** _____

Has your optometrist discussed Laser Vision Correction with you? ☐ Yes ☐ No

Did they refer you to NVISION? ☐ Yes – Which surgeon were you referred to? _____

☐ No – Who were you referred to? _____

Pharmacy: _____ **Phone:** _____ **City:** _____

Primary Insurance: Insurance Co. Name:_____ ID#:_____ Group#: _____

Subscriber Name (if not self):_____Subscriber's Date of Birth (if not self): _____

Secondary Insurance: Insurance Co. Name:_____ ID#:_____Group#: _____

Subscriber Name (if not self): _____Subscriber's Date of Birth (if not self): _____

Vision Insurance: Insurance Co. Name:_____ID#:_____Group#: _____

Subscriber Name (if not self):_____Subscriber's Date of Birth (if not self): _____

Emergency Contact Information/Designated Individuals Release: NVISION Eye Centers may release to, or discuss my personal health information (PHI) (except regarding treatment ☐, payment ☐, and/or administrative operations ☐), with the individuals listed below, verbally or in writing. I understand that NVISION will make best efforts to verify the identity of the designated parties before disclosing PHI. I also understand that I may change any of the Emergency Contact Information/Designated Individuals Release information at any time in writing. **Appointment Reminder Release:** ☐ I authorize NVISION may release my name, treatment date, and contact information to a local partnering Optometrist who may prompt me with annual appointment reminder to facilitate follow up care.

Name: _____ Relationship: _____ Ph#: _____

Name: _____ Relationship: _____ Ph#: _____

My signature below indicates that the information provided above is accurate and complete to the best of my ability, and that you acknowledge you were advised of the Notice of Privacy Practices (NPP) for NVISION. Our NPP provides information about how we may use and disclose your protected information. We encourage you to read it in full. Our NPP is subject to change. The notice of Privacy is available on our website at www.nvisioncenters.com and in our office. You may request a copy of the NNP.

_____ _____

Signature of patient (if over 18) or patient's parent or legal guardian *Date*

_____ _____

If signed by parent or legal guardian, print name *Relationship*