NRV Eye Center Established Patient Registration Update Medical Record # _____

Patient Information:

Full Name: _____
(First) (Middle) (Last)

SS# _____ Date of Birth: _____ ☐Male ☐ Female ☐ Declined

Address: _____
(Street/PO Box) (City) (State) (Zip)

Phone: _____ _____ _____
(Preferred) ☐Cell (Alternate) ☐Cell Alternate) ☐Cell

E-mail: _____ @ _____ . _____

Marital Status: _____ *Student Status*: ☐ Full Time ☐ Part Time ☐ Not a Student

Emergency Contact: _____
(Name) (Phone) (Relationship to Patient)

Medical Insurance: ☐ Yes ☐ Self Pay ☐ Workers Comp.

Primary Insurance: ☐ Self ☐ Spouse ☐ Parent ☐ Other *Policy Holder DOB:* _____

_____ _____ _____
(Insurance Company Name) (Policy Number) (Name of Policy Holder)

Secondary Insurance: ☐ None ☐ Self ☐ Spouse ☐ Parent ☐ Other *Policy Holder DOB:* _____

_____ _____ _____
(Insurance Company Name) (Policy Number) (Name of Policy Holder)

Responsible Party ☐ Self ☐ Other

If other: _____
(Name) (Phone) (Relationship to Patient)

Address: _____
(Street/PO Box) (City) (State) (Zip)

I agree that the information provided on this form is accurate and up to date to the best of my knowledge.

Please list any additional individuals with whom we may discuss your treatment.
(This may be changed at any time)

Name/Relationship	Name/Relationship

Patient signature (or responsible party): _____ Date: _____

Please List All Medications you are Currently Taking Include Over the Counter and Eye Medications		
Medication Name	Dosage (ex. mg)	When Taken (ex. twice a day)

Please list Allergies: ☐ None, or : _____

_____

New Medical History/Hospitalizations/Diagnosis since last visit: _____

_____

_____

Eye Surgery/Problems since last visit: _____

_____

You can email this completed form to: reception@nrveye.com