NRV Eye Center Patient Registration 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

Race: ☐White ☐Asian ☐American Indian/Alaska Native ☐African American ☐Native Hawaiian/Pacific Islander ☐ Declined

Ethnicity: ☐Hispanic/Latino ☐Not Hispanic/Latino ☐Declined *Preferred Language:* _____

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.

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

NRV Eye Center Payment, Insurance Assignment Authorization, and Release of Information

NO SHOW FEE
NRV Eye Center reserves the right to charge a NO SHOW fee for missed appointments. This fee is not covered by insurance. We require 24 hour notice on all cancellations to avoid this fee. Missed Office Appointment fee is $25.00. Missed Surgery fee is $100.00**.** I agree to pay the no show fee if I fail to provide adequate notice of missed appointments.

NON-COVERED SERVICES
Every effort is made to inform our patients of procedures deemed necessary in your treatment that may not be covered by insurance prior to being done. A refraction must be done if you want to us to update your glasses prescription. Most insurance plans do not cover refraction. Medicare DOES NOT cover refraction. Our current fee for refraction is $30.00 I agree to pay for refraction if it is not covered by my insurance.

ASSIGNMENT AND PROMISE TO PAY: In consideration of medical services rendered to me or at my request I assign to NRV Eye Center; to the extent necessary to satisfy my outstanding indebtedness, the right to receive all sums payable to me on my behalf under the terms of any health or liability policy or other arrangement or plan with a third party that provides for payment for medical or health care services. Insurance carriers vary on what they will cover as Vision and Medical services. It is the responsibility of the beneficiary to understand all services included in his or her insurance coverage. This includes Coinsurance, Deductibles, and Non Covered Services. NRV Eye Center will bill according to the actual services rendered and diagnoses found on examination.
I understand that I owe and unconditionally agree to pay NRV Eye Center the full amount charged for medical or health care services rendered to me or my child **that are not paid on my behalf by a third party** within 90 days of the date that the medical services are rendered. I understand that NRV Eye Center may charge late fees and interest fees on old accounts and turn any unpaid accounts to a collection agency after 90days. I further agree to pay reasonable attorney fees and collection costs if my account is placed for collection.

MEDICARE LIFE TIME SIGNATURE AUTHORIZATION: I Request that payment of authorized Medicare benefits be made by either me or on my behalf to NRV Eye Center for any services rendered. I authorize any holder of medical information about me to release to the Health Care Financing Administration and it's agents any information needed to determine these benefits or the benefits payable for related services.

RELEASE OF INFORMATION: I authorize NRV Eye Center to release any and all of my medical and billing information to any physician involved in my treatment; to any health care facility at which I seek treatment; billing; collection; quality assurance or risk management activities, or defense of litigation or anticipated litigation; and to any insurance company, health maintenance organization or other entity which is directed or indirectly responsible for payment and or review of services provided by NRV Eye Center. This does not authorize records to be released to individuals or insurance companies to which I am applying coverage without written consent by me. Medical records will be disposed of privately by shredding according to state law (typically 7 years after last date of service).

_____ _____
(Patient or Parent if Minor) (Date)
Signature is has no expiration unless later revoked in writing by patient.

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

Name/Relationship	Name/Relationship

I understand that NRV Eye Center PC may not condition treatment upon my signing privacy notice authorization and that I have the right to refuse to sign privacy authorization.

I have received provider's Notice of Privacy Practices _____ (initials).
(Located in lobby. Patient's may request a copy)

NAME: _____ **DATE**: _____

Which pharmacy do you use: _____ Location: _____

Who is your medical doctor: _____ Did he/she send you here? ☐Yes ☐No

Check boxes if you experience the following:

Ear, Nose, & Throat

- Hard of hearing ☐
- Ringing in ears ☐
- Vertigo ☐
- Severe balance loss ☐
- Severe allergies ☐

Cardiovascular

- Chest pain ☐
- Dizziness ☐
- Fainting spells ☐
- Shortness of breath ☐
- Irregular heart beat ☐
- Difficulty lying flat ☐
- Heart attack ☐
- Congestive heart failure ☐

Constitutional

- Fatigue/Weakness ☐
- Fever ☐
- Weight gain/loss ☐

Respiratory

- Cough ☐
- Congestion ☐
- Wheezing ☐
- Asthma ☐
- COPD ☐

Gastrointestinal

- Heartburn ☐
- Nausea/Vomiting ☐
- Jaundice/Hepatitis ☐
- Acid Reflux ☐

Genito-Urinary

- Pain/Difficulty ☐
- Blood in urine ☐
- History of kidney stones ☐
- History of STD's ☐
- Prostate problems ☐

Psychiatric

- Anxiety ☐
- Mood swings ☐
- Difficulty Sleeping ☐
- Depression ☐
- Bipolar, Schizophrenia, etc. ☐

Endocrine

- Increased Thirst ☐
- Increased Hunger ☐
- Increased Urination ☐
- Increased Sweating ☐
- Fingernail Changes ☐

*Blood/Lymph Nodes **

- Easy bruising ☐
- Gums bleeding easily ☐
- Prolonged bleeding ☐
- Heavy Aspirin use ☐

Musculoskeletal

- Stiffness ☐
- Arthritis ☐
- Joint pain/swelling ☐

Skin

- Rash/Sores ☐
- Lesions ☐
- Hives/Eczema ☐

Neurological

- Seizures ☐
- Weakness/Paralysis ☐
- Numbness ☐
- Tremors ☐

Immunologic

- Hives ☐
- Itching ☐
- Runny nose ☐
- Sinus pressure ☐

Other/Medical History:

- Diabetic ☐
- High blood pressure ☐
- Tuberculosis ☐
- Stroke ☐
- Cancer ☐
- HIV/AIDS ☐
- High Cholesterol ☐
- Thyroid issue ☐

Other medical history: _____

_____

Ocular History: (Have you ever had the following?)

- Previous eye surgery ☐
- Contact Lens ☐
- Pain ☐
- Double vision ☐
- Glaucoma ☐
- Cataracts ☐
- Dry eyes ☐
- Macular degeneration ☐
- Floaters ☐
- Cornea disease ☐
- Eye injury ☐
- Lazy/crossed eye ☐

Family History: (Blood relatives only)

- Diabetes ☐
- Cancer ☐
- Heart disease ☐
- Stroke ☐
- TB ☐
- Kidney disease ☐
- Blindness ☐
- Cataracts ☐
- Glaucoma ☐
- Macular Degeneration ☐
- Retinal disease ☐
- High blood pressure ☐
- Arthritis ☐
- Lazy/crossed eye ☐

Surgical History: (List **ALL** surgeries you have had)

_____

_____

_____

_____

Allergies to medications/reaction: (if none, write "none")

_____

_____

_____

Are you a smoker? ☐Yes ☐No

If so, how often per day? _____

Do you drink alcohol? ☐Never ☐Infrequently ☐Often (_____ drinks per day)

Do you use other drugs? (Other than prescribed or over the counter) ☐Yes ☐No

If so, types used: _____

Please List All Medications you are Currently Taking (Include Over the Counter and Eye Medications) *If you have your own list, we can make a copy at the front desk. Add additional pages if needed.		
Medication Name	Dosage (ex. mg)	When Taken (ex. twice a day)

Allergies List – Continued Page 2:

_____

_____

_____

Continued Medication List – Page 2		
Medication Name	Dosage (ex. mg)	When Taken (ex. twice a day)

Tedd R. Puckett, M.D., FACS, ABES
NRV Eye Center
106 South Franklin Street, Suite C
Christiansburg, VA 24068
Phone: 540-381-2013 Fax: 540-381-8680 NRVeye.COM

Medical Retina
Cataracts
Glaucoma
Pediatrics
Oculoplastics

4/3/2021

CONSENT FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____ SS#: _____

DOB: _____ Dates of Treatment: _____ to _____

Information to be released from:

Name/Agency _____
Address _____
FAX # _____

Name/Agency _____
Address _____
FAX # _____

Name/Agency _____
Address _____
FAX # _____

Scope of Information to release:

☐ Last 2 exams ☐ Summary Letter
☐ Last 2 Visual Fields ☐ Oldest Exam
☐ OCT - glaucoma Scan ☐ CT/MRI
☐ Operation Report(s) _____
☐ A-Scans
☐ All Records

☐ Send by FAX (up to 20 pages, otherwise mail or E-mail)
☐ Send by Secure E-mail (use encrypted Zip or PDF attachment with unlock code 2013)

Information to be released to: NRV Eye Center PC
106 C South Franklin Street
Christiansburg, VA 24073
Fax: 540-382-8980 *Phone: 540-381-2013*
E-Mail: reception@nrveye.com

Purpose for release:

☐ Continuity of care ☐ Communication ☐ Legal Representation ☐ Other: _____

I certify this authorization is made voluntarily, I understand that the information to be released is protected under state and federal laws and cannot be re-disclosed without my further written consent unless provided for by state and federal law. *A copy may be accepted by the health care facility in lieu of the original.* I understand I may revoke this authorization at any time, except to the extent that action has already been taken. If not previously revoked, this consent will expire one year from the date of signature.

_____ _____ _____ _____
Signature of Patient Date Signature of Parent/ Date
(If less than 18 legal guardian must sign) *Guardian/Representative*

_____ _____
Signature of Witness Date