

SNEADCataract

Eye Physicians

Welcome To Our Practice!

Thank you for scheduling your appointment with **SNEAD**Cataract/Eye Physicians. We appreciate the opportunity to provide you with professional, quality eye care that you can trust.

The new patient forms on our website, can be easily downloaded for you convenience and to save you time on your first visit to our office. Please complete both the New Patient Registration Form and the Medical History Questionnaire and bring them with you.

The following information will also assist you in making your first visit with us a pleasant and satisfying experience.

Please arrive 15 minutes prior to you scheduled time

Please check with your insurance to see if a referral or authorization is needed from your primary care physician. This information can be faxed to us at (239) 936-2532

Your eyes may be dilated for your exam, resulting in blurred vision and sensitivity to sunlight for a few hours – please bring sunglasses, or if you feel more comfortable please arrange for someone to drive you home.

If you should have questions or need to re-schedule your appointment for any reason, please call us at (239) 936-8686 – a 24 hour answering service is available.

We look forward to seeing you and taking care of all your vision needs!

John W. Snead, M.D.
Jay S. Rosen, O.D.
Scott R. Prickett, O.D.

John W. Snead, M.D., F.A.C.S.
Jay S. Rosen O.D., F.A.A.O.
Scott R. Prickett, O.D.
P. Michael Pham, O.D.
Rick A. Robinson, O.D.
Travis A. Gresham III, O.D.

SNEADCataract

Eye Physicians and Surgeons

CHART # _____
LOCATION FM NP BS SI

PATIENT REGISTRATION

Date: _____ Date of Birth: _____ Age: _____ Marital: _____ Sex: M F

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

Local Address: _____
(Street &/or P.O. Box No.) (City) (State) (Zip)

Permanent Address if different than above: _____
(Street &/or P.O. Box No.) (City) (State) (Zip)

Local Phone: _____ Work Phone: _____ Northern Phone: _____

Cellular Phone: _____ E:Mail Address: _____

S.S. # _____ Occupation: _____ Place of Employment: _____

In Case of Emergency Notify: _____ Relationship: _____
(Name) (Phone)

PCP/Family Physician: _____ Phone: _____

Are you or your spouse employed full-time? Yes No Is Medicare your primary insurance? Yes No

OFFICE POLICY REGARDING PAYMENT

We will file your insurance on your behalf for today's visit. We accept Medicare assignment. Today you are responsible for paying deductibles, copays, as well as fees for non-covered services. Managed Care patients are responsible for obtaining authorization from your primary care physician if applicable. You are responsible to pay for any unauthorized visits.

Primary Policy Holder: _____

DOB: _____ S.S. #: _____ Relationship to Patient: _____

HOW DID YOU HEAR ABOUT US? (CHECK ALL THAT APPLY)

Newspaper _____

Radio _____

Television _____

Phone Book _____

Internet _____

Patient/Family Member: _____

Seminar/Special Event: _____

Employee: _____

Eye Doctor/Name: _____

Family Doctor/PCP: _____

Insurance Plan: _____

LIFETIME SIGNATURE AUTHORIZATION

In cases where private insurance and or Medicare claims are to be filed, the following form should be completed. In order for us to submit a claim on your behalf for services, we must have your authorization to release medical information.

I hereby authorize Snead Cataract/Eye Physicians and Surgeons to release all medical information and to submit insurance and other claims on my behalf and request payment of Medicare benefits either to myself or to the party who accepts assignment. I understand that I, the patient, am financially responsible for bills submitted and for any balance not paid by insurance. A copy of this signature is valid as the original.

I also give my permission for a report of my evaluation, treatment, and follow up evaluation to be sent to my referring physician and/or family physician.

I have read the above Office Policy and Lifetime Signature Authorization completely. I understand and accept the policy.

Signed: _____ Witness: _____ Date: _____

FOR MINORS:

I give my permission for my minor child, _____, to be treated by Snead Cataract/Eye Physicians & Surgeons.

Signature of Parent or Guardian _____

MEDICAL HISTORY / REVIEW OF SYSTEMS

(Patient Please Print and Fill in Both Sides Completely)

NAME: _____ CHART #: _____ DATE: _____

Name/Address/Phone Number of your Primary Doctor: _____

EYE HISTORY

	Yes	No		Yes	No		Yes	No
Lazy / Cross Eyed	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Retinal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Blind Eye	<input type="checkbox"/>	<input type="checkbox"/>	Dry Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Eye Pain	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Baggy Eyelids	<input type="checkbox"/>	<input type="checkbox"/>	Other, Please Explain _____		
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	Eye Disease / Injury	<input type="checkbox"/>	<input type="checkbox"/>	_____		

DO YOU HAVE A FAMILY HISTORY OF:

	Yes	No		Yes	No		Yes	No
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Retinal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>			

Do You Wear Contacts?: Yes No Type: Soft Hard How Many Years?: _____
Last Day Worn _____ Do You Wear Monovision Contacts (One for reading, one for distance)?: Yes No

PLEASE ANSWER ALL OF THE FOLOWING QUESTIONS TO THE BEST OF YOUR ABILITY:

Date of Last Eye Exam: _____ Doctor's Name: _____
Are You Using Eye Drops? Yes No Name of Drop: _____
How Many Times a Day? _____

HAVE YOU EVER HAD EYE SURGERY? Yes No Type of Surgery? _____
Which Eye? Right Eye Date: _____
Left Eye Date: _____

HAVE YOU EVER HAD OR BEEN TREATED FOR:

	Yes	No		Yes	No		Yes	No
Vertigo	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>
Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Liver Condition	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Condition	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>
Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Sleeping	<input type="checkbox"/>	<input type="checkbox"/>	Complications with Anesthesia	<input type="checkbox"/>	<input type="checkbox"/>
Weight/Hair Loss	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	Motion Sickness	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety/Depression	<input type="checkbox"/>	<input type="checkbox"/>	Latex Allergy	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Condition	<input type="checkbox"/>	<input type="checkbox"/>
Skin Rash	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Neurological Condition	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Gastro/Intestinal Condition	<input type="checkbox"/>	<input type="checkbox"/>
			Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Lung Condition	<input type="checkbox"/>	<input type="checkbox"/>

PLEASE EXPLAIN IF YOU ANSWER YES TO ANY OF THE ABOVE AND LIST ANY MEDICAL CONDITION OR SURGERY NOT ALREADY LISTED: _____

	Yes	No		_____
Do You Smoke?	<input type="checkbox"/>	<input type="checkbox"/>	How Much Per Day?	_____
Do You Drink Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	How Much Per Day?	_____
Do You Drink Caffeine	<input type="checkbox"/>	<input type="checkbox"/>	How Much Per Day?	_____

PLEASE SEE OTHER SIDE

