John W. Snead, MD, MBA, FACS
Richard M. Davis, MD
Jay S. Rosen, OD, FAAO
Scott R. Prickett, OD
P. Michael Pham, OD

SNEAD Cataract
Eye Physicians

CHART #
LOCATION ______ FM NP SI

PATIENT REGISTRATION

Date: ____________ Date of Birth: ____________ Age: ____________ Marital: ________ Sex: M F

Name: ____
(First) (Middle) (Last)

Local Address: ____
(Street / P.O. Box No.) (City) (State) (Zip)

Permanent
Address if different than above: ____
(Street / 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

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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: ____________

Referring Optometrist: ______________________________ Phone: ____________

Referring MD: ______________________________ Phone: ____________

If other than a physician referral please check the one that best applies to how you heard about us.

❑ Relative/Friend: Name: ______________________________

❑ TV ❑ News-Press ❑ Yellow Pages ❑ Event ❑ Website ❑ Insurance

❑ Other (please be specific): ______________________________

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 ______________________________