

Brad A. Snead, MD, FACS  
John W. Snead, MD, MBA, FACS  
Richard M. Davis, MD  
Allison Coll, OD  
Kate Maloney, OD  
Michael Pham, OD

# SNEAD EYE GROUP

CHART # \_\_\_\_\_  
LOCATION FM NP BS CC

## PATIENT REGISTRATION

Date: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Marital: \_\_\_\_\_ Sex:  M  F

Race/Ethnicity:  Caucasian  Hispanic  African American  Asian  Native American  Other: \_\_\_\_\_

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)

Do you currently reside in a skilled nursing facility?  Yes  No Facility Name: \_\_\_\_\_

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: \_\_\_\_\_

Were you sent to our office by another physician?  Yes  No If yes, who: \_\_\_\_\_

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

Relative/Friend: Name: \_\_\_\_\_

TV  Newspaper Ad  Health Fair  Seminar  Facebook/Email  Insurance  Website

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 EYE GROUP/Eye Physicians and Surgeons of Florida to release all medical information and to submit insurance and other claims, including appeals, 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 EYE GROUP/Eye Physicians and Surgeons of Florida.

Signature of Parent or Guardian: \_\_\_\_\_