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SNEAD EYE GROUP

CHART # _____
LOCATION ◯FM ◯NP ◯PB

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: _____