

**RETURNING PATIENT INTAKE FORM**

Date: \_\_\_\_\_  
 Mr.  Mrs.  Ms.  Dr.  Other \_\_\_\_\_

**Insurance Information**

Please present all of your insurance card(s) to the receptionist so that we may make a copy to complete your records.

\_\_\_\_\_  
Patient

I, the undersigned, certify that I (or my dependent) have insurance coverage with

\_\_\_\_\_  
Address

\_\_\_\_\_  
Vision

\_\_\_\_\_  
City/State/Zip

\_\_\_\_\_  
Medical

\_\_\_\_\_  
Home Phone

\_\_\_\_\_  
Other

\_\_\_\_\_  
Cell Phone

And assign directly to Matthew C. Snyder OD all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance.** I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

\_\_\_\_\_  
Work Phone

\_\_\_\_\_  
Email address

By signing this statement, I understand that my vision and/or health insurance coverage is a contract between myself and my insurance company. Although Dr. Snyder and staff have made every effort to verify my benefits, no guarantee can be made that the information received is accurate since incorrect information may be provided by my insurance company from time to time. I understand that it is ultimately my responsibility as the patient to understand my vision and/or health insurance coverage as well as handle any charges my plan does not cover.

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Married  Divorced  Single  Widowed  Other

**\*ALL PATIENTS SIGN BELOW PLEASE\***

\_\_\_\_\_  
Occupation/Grade

\_\_\_\_\_  
Employer/School

\_\_\_\_\_  
Spouse's name

Do you wear  glasses  contacts  other

\_\_\_\_\_  
Patient/Parent/Guardian

Date

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Has the person who is responsible for this account changed? If yes, who is responsible?

**Eye History**

Any changes in eye history?  Yes  No

If yes, what has changed? \_\_\_\_\_

\_\_\_\_\_  
Name

Do you use eye drops on a regular basis? If so, what and how often?

\_\_\_\_\_  
SSN

\_\_\_\_\_  
Primary Insured's Date of Birth

\_\_\_\_\_  
Relationship

**Family History**

Any changes in Family Ocular history?  Yes  No

**Medical Information Changes?**

\_\_\_\_\_  
Primary Care Physician

\_\_\_\_\_  
Phone

**Review of Systems**

Have there been any changes in your health history? Please check all that apply below.

	Yes	No		Yes	No		Yes	No
Eyes (Ocular symptoms)	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	Neurological	<input type="checkbox"/>	<input type="checkbox"/>
Eyes (Visual symptoms)	<input type="checkbox"/>	<input type="checkbox"/>	Ears, Nose, Mouth, Throat	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>
Vascular/Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>	Integumentary (Skin)	<input type="checkbox"/>	<input type="checkbox"/>	Constitutional	<input type="checkbox"/>	<input type="checkbox"/>
Bones/Joints/Muscles	<input type="checkbox"/>	<input type="checkbox"/>	Lymphatic/Hematologic	<input type="checkbox"/>	<input type="checkbox"/>	Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>						

Other: \_\_\_\_\_

Any major surgeries since your last visit?: \_\_\_\_\_

\_\_\_\_\_

**Medical History**

Medications (including eye drops and over the counter) \_\_\_\_\_

 None

Drug Allergies \_\_\_\_\_

 NoneAre you pregnant and/or nursing?  Yes  No**Social History**Do you drive?  Yes  No If yes, do you have visual difficulty when driving?  Yes  NoDo you use tobacco?  Yes  No If yes, type/amount/how long? \_\_\_\_\_Do you drink alcohol?  Yes  No If yes, type/amount/how long? \_\_\_\_\_Do you use drugs?  Yes  No If yes, type/amount/how long? \_\_\_\_\_**PUPILLARY DILATION INFORMED CONSENT****Dr. Snyder periodically dilates his patients eyes. Based on your risk factors Dr. Snyder may request to dilate you today.**Pupillary Dilation is the use of medicine drops to enlarge the pupil in the eye. This opening of the pupil allows Dr. Snyder to examine the eye more thoroughly allowing Dr. Snyder to see things that could not be seen without the dilation. **Certain eye diseases and abnormalities can go undetected without this test.** Pupillary dilation is an important part of a complete eye health evaluation, and Dr. Snyder recommends this testing. There is no additional cost to you.

The risks and disadvantages of pupillary dilation include: \*Slight burning of the drops (approx. 15 seconds) \* Temporary blurry vision, usually worse up close \* Significant, but temporary light sensitivity (may affect driving, caution is advised) \* Allergic reaction in rare cases.

These affects are short lived for the long-term gain of your eye health.

 Yes, my eyes may be dilated  No, I would not like my eyes dilated  I would like to reschedule for dilation**FUNDUS PHOTOGRAPHY INFORMED CONSENT**We now offer EyeScreen digital retinal photography. This does not replace your annual dilation, but can be used in conjunction with your dilation exam. Insurance is designed to pay for photographs if existing eye disease is present. This screening helps us detect eye disease earlier, and is highly recommended. **Dr. Snyder recommends this procedure for all of his patients and will perform the EyeScreen Exam at an additional cost of \$24 to the comprehensive eye exam you are receiving today.** I AGREE to have my retinal health evaluated with the EyeScreen Exam. Signature \_\_\_\_\_ I DO NOT wish to have the EyeScreen Exam. I understand that I will still have a thorough eye examination with slit lamp observation.**LIFESTYLE QUESTIONNAIRE** Please check any that apply to you:**WORK AND HOBBIES**

- Computer work 3+ hrs./day
- Reading (small print)
- Watching TV/movies
- Cooking
- Writing
- Play musical instrument(s)
- Travel
- Gardening/Landscaping/Yard work
- Woodworking/sawing/carpentry
- Auto repair
- Painting
- Use of power tools
- Use of chemicals/caustic materials
- Sewing/needlepoint/other detail work
- Camping/hiking
- Water sports/sailing/jet ski/boating
- Playing cards/bingo/board games
- Pilot

**SPORTS AND ACTIVITIES**

- Golf
- Tennis/badminton
- Walking/Running
- Volleyball
- Biking
- Soccer
- Baseball/softball
- Skateboard/scooter
- Skating (ice, inline)
- Football
- Basketball
- Skiing/snowboarding
- Swimming
- Bowling
- Racquet ball
- Dancing
- Hunting/shooting
- Weight lifting

**CURRENT EYEWEAR**

- Safety glasses (work and home)
- Sunglasses, Polarized
- Sunglasses, Tinted
- Goggles for swimming
- Goggles for contact sports
- Glasses (everyday use or back-up)
- Computer glasses
- Golf glasses
- Shooting glasses
- Sport specific contact lenses
- Sport specific sunglasses

Any hobby, work activity, sport, or recreational activity we forgot that applies to you? \_\_\_\_\_

Anything else you feel would help us provide you with appropriate solutions to your particular needs?  
\_\_\_\_\_Are you planning on purchasing new glasses today?  Yes  No  Depends