Date: _____
□ Mr. □Mrs. □ Ms. □ Dr. □ Other _____

_____
Patient

_____
Address

_____
City/State/Zip

_____
Cell Phone

_____
Home Phone

_____
Email address

****

□ Married □ Divorced □ Single □ Widowed □ Other

_____
Date of Birth

_____
Occupation/Grade

_____
Employer/School

_____
Spouse's name

How did you hear about our office?
□ Referred by _____
□Facebook/Social Media
□Google □Other _____

When was your last eye exam? _____

Do you wear □ glasses □ contacts □ other
If contacts, what brand and power?

_____

Who is the primary insured?

_____
Name

_____
Last four of social

_____
Date of Birth

Insurance Information

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

Medical Insurance: _____

Vision Insurance: _____

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.

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 cove**

Patient/Parent/Guardian Date

***Would you like access to your patient portal?**

Yes or No

Medical Information

Primary Care Physician and Phone number

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