SNYDER EYE CLINIC/KUNKEL-SNYDER OPTOMETRIC
PATIENT INFORMATION

TODAY'S DATE _____

LAST NAME _____ FIRST NAME _____ MI _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

BIRTHDATE _____ AGE _____ SEX ( ) M OR ( ) F MARITAL STATUS ( ) S ( )M ( ) D ( )W

SOC. SEC. # _____ PHONE: HOME _____ CELL _____

PREFERRED CONTACT METHOD: ( )Phone ( )US Mail ( )Email_____

EMPLOYER _____ WORK PHONE # _____

SPOUSE'S NAME _____ BIRTHDATE _____ WORK # _____

We now have the capability of communicating with you via your email address. We can send exam summaries, recalls, and other information securely and very quickly.

RESPONSIBLE PARTY INFORMATION (If other than patient)

FATHER'S NAME _____ BIRTHDATE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

SOCIAL SECURITY # _____ PHONE _____

EMPLOYER _____ WORK # _____

MOTHER'S NAME _____ BIRTH DATE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

SOCIAL SECURITY # _____ PHONE _____

EMPLOYER _____ WORK # _____

FRIEND OR RELATIVE NOT LIVING AT YOUR ADDRESS

LAST NAME _____ FIRST NAME _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE: HOME _____ RELATIONSHIP _____

PLEASE TURN OVER

Tobacco Status:

( )Current every day smoker
( )Current some day smoker
( )Smoker
( )Current status unknown
( )Never Smoked
( )Former Smoker
( )Unknown if ever smoked

Preferred Language:

( ) English
( ) Spanish
( ) Other _____

Race:

( ) American Indian or Alaskan Native
( ) Black or African American
( ) Native Hawaiian or Other Pacific Islander
( ) Asian
( ) White

Ethnicity:

( ) Not Hispanic or Latino
( ) Hispanic or Latino

Primary Care Physician: _____

Preferred Pharmacy:_____

Snyder Eye Clinic/Kunkel-Snyder Optometric has my permission to file claims and receive payments from my insurance benefit for today's services and goods. I understand that I am responsible for any amount that is not covered by my insurance.

Patient Signature:_____Date:_____

SNYDER EYE CLINIC
KUNKEL-SNYDER OPTOMETRIC, P.C.

Wayne E. Snyder, M.D.
Board Certified Ophthalmologist

Beth A. Kunkel, O.D. *Optometrist*
Matthew C. Kunkel, O.D. *Optometrist*

1225 4TH STREET NE • WATERTOWN, SD 57201
605-882-4175· 800-568-4224· FAX 605-882-2962

HEALTH HISTORY

PATIENT NAME: _____

DATE OF BIRTH: _____

PLEASE FILL OUT THE FOLLOWING INFORMATION BY PLACING AN (X) IN THE BOX IF THIS INFORMATION PERTAINS TO YOU:

CARDIOVASCULAR

( ) Angina ( ) Irregular Heart Beat ( ) Bypass Graft ( )Chest Pain ( ) Heart Murmur
( ) Congestive Heart Failure ( ) Coronary Artery Disease ( ) Heart Palpitation
( ) High Blood Pressure ( ) High Cholesterol ( ) Mitral Valve Prolapse ( ) Blood Clots
( ) Pace Maker ( ) Valve Replacement ( ) Rheumatic Fever ( ) _____

RESPIRATORY

( ) Asthma ( ) Bronchitis ( ) Shortness of Breath ( ) Emphysema ( ) Pneumonia
( ) COPD ( ) Tuberculosis ( ) Obstructive Sleep Apnea ( ) Home Oxygen ( ) Cough
( ) _____

GASTROINTESTINAL

( ) Abdominal Pain ( ) Bowel Cancer ( )Change in Appetite ( ) Constipation ( ) Diarrhea
( ) Difficulty swallowing ( ) Ulcers ( ) Diverticulitis ( ) Gallbladder Disease ( ) Nausea
( ) Reflux/Heartburn ( ) Hiatal Hernia ( ) Hepatitis ( ) Liver Disease ( ) Jaundice
( ) Pancreatitis ( ) _____

GENITOURINARY/ENDOCRINE

( ) Bladder Infections ( ) Bladder Repair ( ) Bladder Spasms ( ) Frequent Urination
( ) Recurrent Urinary Infections ( ) Changes in Color of Urine ( ) Incontinence
( ) Kidney Failure ( ) Kidney Stones ( ) Kidney Transplant ( ) Diabetes ( ) Dialysis
( ) Thyroid Disorder ( ) _____

MUSCULOSKELTAL

( ) Back Pain ( ) Neck Pain ( ) Cerebral Palsy ( ) Gout ( ) Rheumatoid Arthritis
( ) Multiple Sclerosis ( ) Muscular Dystrophy ( ) Parkinson's ( ) _____

NEUROLOGICAL/PSYCHIATRIC

( ) Bells Palsy ( ) Cranial Nerve Palsy ( ) Paralysis ( ) Epilepsy ( ) Migraines ( ) Seizures
( ) Dizziness ( ) Stroke ( ) TIA ( ) Depression ( ) Dementia ( ) Panic Episodes
( ) Anxiety ( ) _____

ALLERGIC/IMMUNOLOGIC

( ) HIV ( ) Immune Disorder ( ) Lupus ( ) Seasonal Allergies ( ) Allergy Shots

OTHER

( ) Basal Cell Carcinoma ( ) Bruising ( ) Dermatitis ( ) Eczema ( ) Excessive Sweating
( ) Itching ( ) Psoriasis ( ) Skin Cancer ( ) Skin Rash ( ) Cancer _____
( ) Hearing Aides ( ) Dentures ( ) _____

HEALTH HISTORY CONTINUED: please complete other side

PREVIOUS SURGERIES:

_____
_____
_____
_____
_____

ALLERGIES:

_____
_____
_____
_____
_____

CURRENT PRESCRIPTION/OVER THE COUNTER MEDICATIONS

MEDICATION NAME **DOSE** **FREQUENCY**

_____
_____
_____
_____
_____
_____
_____
_____
_____

IF YOU HAVE DIFFICULTY COMPLETING YOUR MEDICATION LIST PLEASE CONTACT YOUR PHARMACY AND ASK THEM TO SEND YOU A PRINTED LIST OF YOUR CURRENT MEDICATIONS AND BRING IT ALONG TO YOUR APPOINTMENT.

YOU ARE SCHEDULED TO SEE:

( ) DR. WAYNE SNYDER, M.D. _____AT_____

( ) DR. MATTHEW KUNKEL,O.D. _____AT _____

( ) DR. BETH KUNKEL, O.D _____AT _____

Your initial evaluation of a cataract will take approximately 1 hour. If you decide to schedule cataract surgery additional time will be needed for scheduling and instructions. Please bring your schedule with you, if you choose to schedule surgery a date is usually decided at this appointment. Please fill out this form completely and mail back or bring to your appointment.

How did you hear about us? (Circle one please)
Radio / Movie Theater / Phone Book / Newspaper / Tidbits / Family or Friend / Other physician or doctor
Other_____