



Kathleen J. Dennis-Zarate M.D. & Kay L. Park M.D. 818-551-7127 Fax: (818)551-7131

DEMOGRAPHICS

PATIENT INFORMATION (please print)

Date: _____

First Name: _____ MI: _____ Last Name: _____

Birthdate: _____ Age: _____ Birth Sex: [] M [] F (Preferred Gender: _____ Preferred Pronouns: [] _____)

Address: _____ Apt#: _____ City: _____

State: _____ Zip Code: _____ CDL/ID#: _____ Social Security#: _____ (last 4 digits)

CELL Phone # () _____ Alternate Phone#: () _____

Relationship status : [] Single [] Married [] Divorced [] Widowed [] Other: _____ EMAIL: _____

Primary Language Spoken: _____ Preferred Method of Contact: [] Phone [] Text [] Email:

Race: [] American Indian or Alaska Native [] Asian [] Black or African American [] Caucasian [] Hispanic [] Other

Ethnicity: [] White [] Non-Hispanic [] Hispanic/Latino [] Other _____

Emergency contact: _____ Phone #: _____ Relation: _____

Employer or School: _____ Address: _____ Occupation: _____ Employer phone#: () _____

Domestic Partner ↓ Spouses Name: _____ Spouses Work# () _____ Spouses Employer: _____ Spouses Birthdate: _____

WHERE CAN DETAILED MESSAGES BE LEFT? [] Home [] Cellphone [] Email [] NO Disclosure [] Other: _____

INSURANCE

Primary Medical Insurance: ↓ Insurance Co: _____ Policy/ID #: _____ Group #: _____ Subscriber's Name: _____ SS#: _____ DOB: _____ Relation: _____

Secondary Medical Insurance ↓ Insurance Co: _____ Policy/ID #: _____ Group #: _____ Subscriber's Name: _____ SS#: _____ DOB: _____ Relation: _____

Vision Insurance: Insurance Co: _____ Policy/ID #: _____

MEDICAL INFORMATION:

Primary Care Physician: _____ Phone# _____

PHARMACY Name: _____ Location: _____ Phone# _____

Financial Agreement-Assignment

VISA/MASTERCARD/AMEX ACCEPTED

My signature below certifies that the above information provided to the office is current. I hereby authorize that My Insurance Company pay directly to Dr. Kathleen Dennis-Zarate (Vision Care Medical Group) for services rendered to me by Dr. Kathleen J. Dennis-Zarate and/or Dr. Kay L. Park. I also authorize that any information requested by my insurance company or Healthcare Financing Administration be provided for any financial payments, benefits payable for services provided. I request that Medicare and/or insurance payments/benefits be made on behalf for any services furnished to me. All copays and fees not covered by insurance are payable at time of service and am liable for incurred charges for Ophthalmology service

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all incurred charges whether or not paid by said insurance. I hereby authorized assignee to release all information necessary to secure payment. It is your responsibility to pay any deductible amounts, co-insurance or other balance not paid by your insurance carrier.

Patients Signature: _____ Date: _____ Insured's signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND PATIENT CONSENT FORM

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I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- **Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.**
- **Obtain payment from third-party payers.**
- **Conduct normal healthcare operations such as quality assessments and physician certifications.**

I have received, read and understand *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at any address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I understand you are not required to agree to my request restrictions, but if you agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent. I authorize that my disclosure of my protected health information be discussed and disclosed to the following:

(1) Name: _____ Relationship: _____
 (2) Name: _____ Relationship: _____
 (3) Name: _____ Relationship: _____

I understand that this authorization may be revoked by a written notification and is valid until I submit a written request. By signing below, I am attesting that I have a legal right to authorize the release of my protected health information.

Patient Name: _____ Birthdate: _____

Signature: _____ Date: _____
(Relationship to patient (if signing as legally authorized representative/or if patient is a minor

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below;

Date:	Initials:	Reason:
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PATIENT HISTORY FORM

Date: _____

Name: _____ DOB: _____ Age: _____

Employment Status: Employed Unemployed Retired Student Active Military

Occupation: _____ Employer: _____ Hobbies: _____

Last eye exam: _____ Pharmacy Name: _____

• Primary Care Physician: _____ Last PCP Visit: _____

Do you wear: None Glasses Contact Lenses: _____
(Contact Lens Brand)

• Purpose of today's visit (please check all that apply):

- Blurry Vision Headaches Eye pain Double vision Glare
- Difficulty with night vision Focusing issues Loss of vision Floaters Flashes of light
- Burning Itchiness Redness Watery eyes Dryness
- Other: _____

• Have you ever been diagnosed with or previously had any of the following eye conditions? None

- Corneal Abrasion Corneal Ulcer Uveitis Glaucoma Diabetic Retinopathy
- Lazy Eye/Amblyopia Dry Eye Eye injury Retinal Hole/Tear Macular Degeneration
- Eye Turn/Strabismus Eye infection Cataracts Retinal Detachment Blindness
- Other eye diseases: _____

• History of eye surgery?: No Yes: _____

• Vision Correction Surgery: No Yes type: Lasik PRK Other _____ When: _____

• Do you see an ophthalmologist/eye specialist? No Yes: _____

• Do you have any other specialists?: No Yes: _____

• Are you currently pregnant or nursing? N/A No Yes

• Do you drink alcohol? No Yes Do you use recreational drugs? No Yes

• Do you smoke? Never Former Smoker Current smoker: How often? _____

• Have you ever been diagnosed or treated for any of the following health problems? None

- Allergies Anxiety Disorder Arthritis Asthma Autoimmune Cancer Concussion
- COPD Crohn's Depression Diabetes GERD Heart Disease/CHF
- High blood pressure High cholesterol Kidney disease Migraines Ulcerative Colitis
- Reproductive/STD Seizures Sinus Stroke Thyroid disease Vertigo

• Please list all medications and over the counter supplements you currently take: None

• Medication allergies: None Yes: _____

• Please list any prior surgeries and approximate dates: _____

- Has anyone in your family ever been diagnosed with any of the following conditions? None
- Blindness Eye Turn/Strabismus Lazy Eye/Amblyopia Keratoconus Cataracts Glaucoma
 - Macular Degeneration Retinal Detachment Cancer Diabetes Heart Disease Thyroid disease