Kathleen J. Dennis-Zarate, M.D. Kay Park, M.D.

PATIENT INFORMATION (please print)

Date: __________________ Patient ID #:_____________

Name: ____**Birthdate:**____________ **Age:**_______ **Sex: M F**
(last name first name middle)
Address:____**Apt#:**__________**City,**_____________________
State: _____ **Zipcode:**__________ **CDL/ID#:**_________________ **Social Security#:**_____________________ *(last 4 digits)*
Home Phone #; ( )_ ___________________________ **Cell Phone#:( )** ___________________________

Marital status: [] Married []Divorced [] Single []Widowed []Separated ***EMAIL:*** _______________________________

Employer: _________________________________ Address:____________________________________
Occupation:________________________________ Employer phone#: ( )______________________
Domestic Partner↓
Spouses Name:_____________________________ Spouses Work# ( )______________________
Spouses Employer;__________________________ Spouses Birthdate:___________________________

Nearest Relative: _________________________________ Relatives phone#:___________________________
Relatives Address: ____Relationship:____________________

Who Recommended us to you ? [ ] Friend/Relative __________________ [ ] Doctor __ __________________
[ ] Yellow pages [ ] Television [ ] Other _____________________________

INSURANCE INFORMATION:
PRIMARY:
Insurance Company/Carrier:__________________________________Phone#:________________________
Address;____
Group#:______________________ ID#:___________________________

Medicare#:____________________________________ **Medi-cal**#:__________________________________

SECONDARY INSURANCE: Insurance Company: ____________________________________ phone#:________________
Group#:_______________________ ID#:_________________________
____
MEDICAL INFORMATION:
Do you have any health problems? [ ] Diabetes [ ] High Blood pressure [ ] Heart disease [ ] Asthma/Emphysema

List eye drops you are currently using and dosages of each. (please bring your eye drops with you)__________________
.____.
FAMILY DOCTOR: ______________________________ Optometrist:________________________________

FINANCIAL ASSIGNMENT AND AGREEMENT: **VISA/MASTERCARD 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.

This assignment will remain in effect unit 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.

Signature: ____ Date;___________________________
(Patient or Insured)

Insured's signature: ____________________________________ Date: ___________________________

Vision Care Medical Group

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