# PACIFIC RETINA SPECIALISTS

## DAVID J. PARKS, M.D.

### PATIENT INFORMATION

Patient Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip code _____

Home Phone ☐ _____ Work Phone ☐ _____ Cell Phone ☐ _____

**Please check box to indicate which is your preferred contact phone number**

Email Address_____

☐ Male ☐ Female Social Security # _____ Driver License # _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed ☐ Unknown

Spouse Name (if married) or Parent Name (if minor) _____

Preferred Language _____

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Decline to Specify
- ☐ Unknown

Race:
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Other Race
- ☐ Declined to Specify

### OTHER INFORMATION

Emergency Contact _____ Relationship _____ Phone _____

Pharmacy Name _____ Location _____ Phone _____

Primary Care Physician _____ Phone _____

Primary Ophthalmologist _____ Phone _____

### PRIMARY INSURANCE INFORMATION

Insurance Carrier _____ ID # _____ Group # _____

Subscriber Name _____ Subscriber's Date of Birth _____

Subscriber's Relationship to Patient _____

### SECONDARY INSURANCE

Insurance Carrier _____ ID# _____Group # _____

Subscriber Name _____ Subscriber's Date of Birth _____

Subscriber's Relationship to Patient _____

### AUTHORIZATION FOR TREATMENT AND RELEASE OF MEDICAL RECORDS

I hereby authorize **Dr. David J. Parks** and assistants to treat me. Also, by signing below I am authorizing for **David J. Parks, M.D., Inc.** and its doctors to furnish the above insurance companies all the necessary information which they may request. It is the policy of David J. Parks, M.D., Inc. to require payment at the time services are provided. In the event the patient is in a prepaid plan only the co-payment portion is applicable. By signing below I am stating that I understand this policy. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediate carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or the party who accepts assignment below. I hereby irrevocably assign to the doctor all payments for medical services rendered and ALL MAJOR MEDICAL BENEFITS, from my insurance companies and Medicare.

_____ _____ _____ _____

(Patient's or guardian's signature) (Date) (Signature of Insured) (Date)