George H. Garcia, MD, Inc.
Ophthalmic Plastic & Reconstructive Surgery
Assistant Clinical Professor at the UCLA School of Medicine/Jules Stein Eye Institute

Patient Health Information Form

Patient name:_____ Date:_____

Address:_____
Street City State Zip

Home Phone:_____/_____ Work Phone:_____/_____

Status (circle one): Single - Married - Divorced - Widowed Spouse's Name:_____

Social Security Number:_____ Date of birth:_____/_____/_____ Age:____

Occupation:_____ Employer:_____

Emergency Contact:_____ Phone:_____/_____
relationship to patient

Your Family Doctor:_____ City:_____

How did you learn of our practice?_____

Past or current medical problems_____
_____

Previous surgeries_____
_____

Current medication(s)_____
_____

Allergies? Y / N Allergic to what? _____ What happens?_____

Do you use cigarettes/tobacco? _____ How much?_____
Do you consume alcohol? _____ How much?_____ Other substance(s)?_____
Are you pregnant, or possibly pregnant? _____
Do you have medical insurance? _____ If Yes, please notify the Receptionist.

I request that payment of authorized medical insurance benefits be made on my behalf to George H. Garcia, MD, for services furnished to me by George H. Garcia, MD. I authorize any holder of medical information about me to release to the appropriate medical insurance administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown.

If so determined by a written contract between George H. Garcia, MD, and my medical insurer, then George H. Garcia, MD, accepts the charge determination of the insurance carrier as the full charge, and I am responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and deductible are based upon the charge determination of the medical insurance carrier. If no contract exists between George H. Garcia, MD, and my insurance, then I agree to accept full responsibility for the difference between the insurance reimbursement received by Dr. Garcia and the charges for services rendered.

If I have HMO medical insurance, I accept responsibility for all charges for services furnished to me by George H. Garcia, MD, in the event that it is determined that I was not eligible or authorized to receive such services at the time of service.

Patient signature_____ date:_____