Dr. Hernandez Optometry

15330 Amar Rd. Ste A, La Puente CA 91744
(626) 961-0432

1235 Buena Vista, Duarte CA 91010
(626) 359-8145

Last Name:
Apellido**:**_____

First Name:
Primer Nombre:_____

Title: **Middle Initial:**
Titulo:_____ Middle Initial:_____

[ ]Doctor/Doctor
[ ]Master/Master
[ ]Miss/Srta
[ ]Mrs/Sra
[ ]Mr/Sr.
[ ]Ms/Joven

Address:
Direccion:_____

City:
Ciudad:_____

State: **ZIP:**
Estado: [ ]CA Zona**:**_____

Home Phone:
Telefono de casa: **(____)** _____-_____

Daytime Phone:
Telefono de dia: **(____)** _____-_____

Cellphone:
Cellular: **(____)** _____-_____

E-mail:_____

Would you like to receive confirmation of appointments and notifications via:
Gustaría recibir confirmación de citas y notificaciones a través de:
E-mail: [ ]YES/SI **[ ]NO**/NO
Text: [ ]YES/SI **[ ]NO**/NO

Date of last eye exam:
Ultimo examen: _____/_____/_____

Previous eye doctor:
Ultimo Optometrista:_____

Sex:
Sexo: [ ]M [ ]F

Date of Birth:
Fecha de Nacimiento:_____/_____/_____

Social Security:
Seguro Social:_____-_____-_____

Source:

[ ]Direct Mail/Por Correo
[ ]Family Referral/Miembro de su familia
[ ]Insurance List
[ ]Patient Referral/Por un paciente
[ ]Professional Referral
[ ]Television
[ ]Walk-in
[ ]Web Page/Internet
[ ]Yelp/Facebook
[ ]Word of Mouth
[ ]Yellow Pages/Las paginas amarillas

Referred By: [ ]Patient [ ]Professional
Referred Name:
Persona que la recomendo:

Vision Insurance Type/Seguro de vision:

[ ]Medicare/Medi-Cal
[ ]MES
[ ]VSP
[ ]Other:_____

Primary Care Physician:
Doctor Primario:_____

PCP Phone Number/ Telefono de Doctor primario:_____

Medical Insurance:
Seguro Medico:_____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I herby authorize my insurance benefits be paid directly to Dr Hernandez, and I am financially responsible for non-covered services. I also authorize the Doctor to release any information required to carry out treatment, payment activities, and healthcare operations.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Dr Hernandez's Notice of Privacy Practices

X_____ Date_____/_____/_____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:
Personal Representative's Name:_____Relationship to Patient:_____