Claudio S. Contreras, M.D., Inc. **Diplomate, American Board of Ophthalmology**
Eye Physician and Surgeon

2120 McKee Rd
San José, CA 95116

Patient Information

Last Name, First Name:_____Gender:_____

Birthdate:_____

Address:_____City:_____

State:_____Zip code:_____

Married:_____Single:_____Widow(er)_____Divorced:_____

Per Government Request we are required to ask you:

Language:_____ Race:_____ Ethnicity:_____

Email:_____

When it becomes necessary to contact you by phone, please list the number(s) where you wish us to call.
Telephone:_____Second Telephone: _____
May we leave messages and appointment information on an answering device, or with another person who answers the telephone, at that number? Yes [ ] No [ ]
Name and telephone number of emergency contact person not living with you_____
#_____

Referred by ☐Primary care doctor ☐Optometrist ☐ Patient ☐ Internet ☐ Other

Name _____

Medical Insurance Authorization

I,_____authorize my medical insurance company to reimburse Claudio S. Contreras MD Inc. for consultation and treatment provided to me. **Where permitted, I am responsible for the medical claim in the event that said insurance company should not provide reimbursement for medical services provided to me.** I authorize Dr. Contreras to provide copy of medical records to insurance company representatives who may require them to process the claim for payment or to other physicians who may consult on my care.

Signature_____Date_____
(Parent or guardian's signature for care of minor)

Claudio S. Contreras, M.D.
Eye Physician and Surgeon
Médico Y Cirujano de los Ojos

Diplomate, American Board of Ophthalmology

Acknowledgement of Receipt of Notice of Privacy Practices

Claudio S. Contreras, M.D., Inc.
2120 McKee RD
San José, CA 95116

Privacy Officer: Claudio S. Contreras, M.D. Tel: 408 971-2020

Policy Date April 20, 2015

I hereby acknowledge that I was informed of this medical practice's Notice of Privacy Practices. I acknowledge that a copy of the current notice is posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Signed:_____Date:_____

Print Name: _____

If not signed by the patient, please indicate:

Relationship:

- ☐ parent or guardian of minor patient
- ☐ guardian or conservator of an incompetent patient
- ☐ beneficiary or personal representative of deceased patient

Name of Patient: _____

Reason for Refusal to sign_____

Identity of the patient was verified by checking government issued ID card

- ☐ CA Drivers License
- ☐ CA ID
- ☐ Other:_____

Staff Name: _____