DESERT EYE ASSOCIATES, LTD.
PATIENT DEMOGRAPHICS

Jack A. Aaron, M.D. *Karl A. Rosen, M.D.* *Carmen Felix Tacoronte, M.D.* *Timothy E. Marra, D.O.*
Zachary G. Pfau, O.D. *Stephanie Burruel, O.D.*

Last Name First Name Middle Initial

Sex: Birth Date: Social Security Number:

Address: City: State: Zip Code:

Cell Phone: Home Phone: Work Phone:

Email Address: Marital Status:

Primary Care Physician: Referring Provider:

Pharmacy Name & Cross Streets

Employer: Occupation: Retired: YES ☐ NO ☐

Preferred Language: Race: Ethnicity:

Desert Eye Associates, Ltd. does not discriminate based on race, age, sex, or ethnicity.

Please bring the following to every appointment:
Current Insurance Card(s) – Referral (if required)
Picture I.D. - List of Medications including Eye Drops
FACE MASK REQUIRED

PROTECTED HEALTH INFORMATION
Please checkmark **ONLY ONE** of the following.

☐ Desert Eye Associates, Ltd. **may** disclose my medical and financial information to the following individual(s), please list their relationship to you.

Spouse: _____ Child (children): _____

Other: _____ Relation: _____

☐ Desert Eye Associates, Ltd. **may** release my medical or financial information to **any person**.

☐ Desert Eye Associates, Ltd. **may NOT** disclose my medical or financial information. The exception to this will be dictated by any Federal or State laws, regulations, or statues.

HIPAA INFORMATION:
In signing this form, I am giving permission for any agent of Desert Eye Associates, Ltd., to speak to anyone answering the above phone numbers or to leave any message on an answering machine. I also understand I may receive postcards to schedule appointments. I understand my name will be used on a sign-in log at check-in for all appointments. I also acknowledge that I have been presented a copy of the 'Notice of Privacy Practices' for Desert Eye Associates, Ltd. I will inform Desert Eye Associates, Ltd. in writing of any person(s) I do not want my 'Protected Health Information' disclosed to. **This is a lifetime signature unless revoked in writing by patient**.

MEDICARE AND INSURANCE ACKNOWLEDGEMENT:
I request that payment of authorized benefits be made on my behalf to Desert Eye Associates, Ltd. for services furnished by Desert Eye Associates, Ltd. I agree to be responsible for any deductibles, copay, coinsurances, refractions, disallowed, and non-covered services not paid for by my insurance carrier(s). Should my insurance carrier change it shall be my responsibility to inform and supply Desert Eye Associates, Ltd., with a copy of my new insurance card(s) and correct billing information before my visit or I will assume responsibility for charges incurred.

SIGNATURE **DATE**