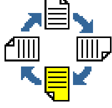
Rotate:



Zoom: 30% 50% 80% [100%] 150%

Pages: 1, 2, 3

SUZANNE MARIENAU CARDOZA, O.D.
665 N. DOUTY STREET
HANFORD, CALIFORNIA 93230
PHONE (559) 582 – 4316

PATIENT'S NAME____________________ DATE OF BIRTH________ SEX______

( ) CHILD ( ) UNMARRIED ( ) MARRIED ( ) SEPARATED ( ) OTHER________ SOC. SEC. #__________

ADDRESS____________________ PHONE__________
(Number & Street) (Town) (State/Zip)

MAILING ADDRESS____________________

PREVIOUS ADDRESS____________________
(Number & street) (Town) (State/Zip)

PATIENT AND/OR RESPONDSIBLE PARTY'S OCCUPATION____________________

PATIENT'S EMPLOYER____________________ PHONE__________
(Name & Address)

IS THE PATIENT A STUDENT____________________ ( ) FULL TIME ( ) PART TIME GRADE________
(School attending)

PARENT'S OR SPOUSE'S NAME____________________ SOC. SEC. #__________

PARENT'S OR SPOUSE'S OCCUPATION____________________

PARENT'S OR SPOUSE'S EMPLOYER____________________
(Name & Address)

RELATIVE WHOM WE CAN CONTACT IN EVENT OF EMERGENCY

NAME____________________ PHONE__________
(Last) (First) (Middle)

ADDRESS____________________ MESSAGE #__________

PERSONAL PHYSICIAN'S NAME____________________

REFFERED BY: ( ) DR.____________________ ( ) HOSPITAL____________________
( ) EMPLOYER____________________ ( ) OTHER____________________

HAS ANY MEMBER OF YOUR FAMILY EVER BEEN TREATED AT THIS OFFICE? ( )YES ( )NO ( )I DON'T KNOW

ARE YOU ALLERGIC TO ANY MEDICINE? ( ) YES ( ) NO ( ) I DON'T KNOW
IF YES, WRITE THE NAME OF THE MEDICINE HERE____________________

METHOD OF PAYMENT (CHECK ONE OR MORE)
( ) CASH/CHECK ( ) MASTER CHARGE ( ) VISA
( ) PRIVATE INSURANCE:
INSURANCE INFORMATION: MEDICARE#____________________ ( ) INSURANCE__________

____
(SUBSCRIBER NAME) (CERTIFICATE #) (GROUP #)

____
(EFFECTIVE DATE) (CURRENT COVERAGE) (# OF PERSONS COVERED)

SIGNATURE____________________ DATE__________
(RESPONSIBLE PERSON)