Mark S. Kita, M.D.
14651 South Bascom Avenue, Suite 240
Los Gatos, CA 95032

Today's Date:

Referred by:

Family MD:

GENERAL INFORMATION

Marital Status:

Birthplace:

Patient Last Name	First	Middle	Social Security No.
Street Address			Sex: / Birthdate: / Ethnicity:
City	State	Zip Code	Home Phone: / Other Phone:
Employer's Name			Occupation
Employer's Address			Work Phone
Nearest Relative (not living with you) & Relationship		Address	Phone No.
In an Emergency Contact:		Phone No.	

Responsible Party:

INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER

Insurance Company	Group No.	Policy ID No. - Subscriber No.
Billing Address		Policyholder's Birthdate
Name of Policyholder	Patient's relationship to Policyholder	Policyholder's Social Security No.

SECONDARY INSURANCE CARRIER

Insurance Company	Group No.	Policy ID No. - Subscriber No.
Billing Address		Policyholder's Birthdate
Name of Policyholder	Patient's relationship to Policyholder	Policyholder's Social Security No.

PLEASE FILL OUT INFORMATION ON REVERSE SIDE

MEDICAL INFORMATION

Current Medications:	Drug or Environmental Allergies:
Past Surgeries:	

CONSENTS

ALL MEDICARE PATIENTS - PLEASE READ & SIGN

I request that payment of authorized Medicare benefits be made to the physician/supplier for any services furnished by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as Co-insurance and the deductibles are based upon the charge determination of the Medicare carrier.

Beneficiary Signature _____ Date _____

ALL PATIENTS – PLEASE READ & SIGN

I verify that I do not have MEDI-CAL or Medicaid insurance as either my primary or secondary insurance.

Signature _____ Date _____

ALL PATIENTS - PLEASE READ & SIGN

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS. I ALSO AUTHORIZE PAYMENT DIRECTLY TO DR. MARK S. KITA OF ANY INSURANCE BENEFITS DUE TO DR. KITA.

I UNDERSTAND THAT, REGARDLESS OF INSURANCE, I AM RESPONSIBLE FOR THE PAYMENT OF ANY CHARGES INCURRED FOR SERVICES PROVIDED.

Signature (Insured Person) _____ Date _____

Signature (Non-insured Person) _____ Date _____