KETCHUM HEALTH
University Eye Center

WELCOME TO THE UNIVERSITY EYE CENTER!

Please PRINT clearly and neatly

Section 1 Patient Information

_____

Last First Middle Initial Title

_____

Last four digits of SSN# Date of Birth Gender: ☐ Female ☐ Male

_____

Home Address City State Zip

Home#:_____Cell#:_____

Email Address: _____

☐ Please do not send me periodic emails with special information or offers. (Your email is never sold or used for other purposes)

Race

☐ Caucasian / White ☐ African American ☐ Asian ☐ American Indian

☐ Hispanic / Latino ☐ Pacific Islander ☐ Other ☐ Decline to Answer

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Preferred language if not English

_____

Section 2 Responsible Party/Parent/Guarantor

Relationship to Patient ☐ Self (skip) ☐ Spouse ☐ Parent ☐ Other _____

_____

Last First Middle Initial Title

_____

Last four digits of SSN# Date of Birth Gender: ☐ Female ☐ Male

_____

Home Address ☐ Same as Patient's City State Zip

I authorize the University Eye Center, Anaheim to treat/care for this child under the general supervision of any staff optometrist. This consent is given pursuant to the provisions of section 25.8 of the Civil Code of California.

Signature _____ Date _____

Section 3 Emergency Contact Information

_____

Last First Relationship to Patient

Preferred Phone ☐ Home ☐ Work ☐ Cell_____

Section 4 Privacy Rights Acknowledgement

I have read the University Eye Center, Anaheim Privacy Notice and understand my rights contained therein. By way of my signature, I acknowledge that the University Eye Center has provided me with a policy regarding the use and disclosure of my protected health care information for the purposes of treatment, payment, and health care operations as described in the Privacy Notice. A copy shall be as valid as the original.

Signature _____ Date_____

Section 5 Primary Insurance Information

Relationship to Patient ☐ Self (skip) ☐ Spouse ☐ Parent ☐ Other _____

_____

Last First Middle Initial

_____

Last four digits of SSN# Date of Birth Gender: ☐ Female ☐ Male

Section 6 Vision Insurance Information (VSP, Eyemed, MES)

Present your insurance card(s) to the receptionist

Name of Insurance_____	Name of Insurance_____
Member ID#_____	Member ID#_____

Section 7 Medical Insurance Information (Anthem Blue Cross, Blue Shield, Medicare, Medi-Cal, and supplemental)

Present your insurance card(s) to the receptionist

Name of Insurance_____	Name of Insurance_____
Member ID#_____	Member ID#_____