Marshall B.
KETCHUM UNIVERSITY
Southern California College of Optometry
University Eye Center at Los Angeles

WELCOME TO THE
UNIVERSITY EYE CENTER AT LOS ANGELES!

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#:_____ Alternate#_____

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 for patients less than 18 years old

Relationship to Patient ☐ Self (skip this section) ☐ 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 Eye Care Center 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 Eye Care Center Privacy Notice (green form) and understand my rights contained therein. By way of my signature, I acknowledge that the Eye Care 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_____

(Turn Over)

Section 5 Primary Insurance Information

Relationship to Patient ☐ Self (skip this section) ☐ 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) We do not accept HMO's

Present your insurance card(s) to the receptionist

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

☐ **If the patient is covered by more than one plan, please use the below boxes to list plan(s) type.**

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