LOW VISION INTAKE

University Eye Center at Los Angeles | 3916 S. Broadway, Los Angeles, CA 90037

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 Phone Cell Phone

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 under 18 years old

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 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 _____