



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

Preferred language if not English _____

Ethnicity:

- Hispanic Non-Hispanic

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 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, Anaheim 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 _____ Member ID# _____	Name of Insurance _____ Member ID# _____
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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 _____ Member ID# _____	Name of Insurance _____ Member ID# _____
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If the patient is covered by more than one plan, please use the below boxes to list plan(s) type.

Name of Insurance _____ Member ID# _____	Name of Insurance _____ Member ID# _____
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