KETCHUM HEALTH
University Eye Center

Welcome to the University Eye Center!

Today's Date: ____________________

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 ____________ City ____________ State ____________ Zip ____________

☐ Same as Patient's

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 ____________

(continued on back)

SECTION 5: INSURED INFORMATION

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*

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# ____________

SECTION 8: HOW DID YOU HEAR ABOUT US?

How did you hear about us? *Please check all that apply*.

☐ Referred by doctor
☐ Recommended by friend or family
☐ Online Search
☐ Online Ad
☐ Social Media Ad: Facebook
☐ Social Media Ad: Instagram
☐ Other ____________

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ketchumhealth.org