# OMNI EYE SERVICES

**Name:** _____ **DOB:** _____

**Communication Preference:** Phone Mail Email

**Email Address:** _____

**Security Question for Patient Portal:** Mother's Maiden Name _____

**Race:**
American Indian or Alaskan Native
Black or African American
Asian
Eskimo
Hispanic or Latino
Native Hawaiian or Pacific Islander
White or Caucasian
Other: _____

**Ethnicity:**
Hispanic or Latino
Not Hispanic or Latino

**Primary Language:** Chinese English French German Italian
Japanese Portuguese Russian Spanish Other_____

## Personal Health Information

**Who may we discuss your Personal Health Information with?**

Name: _____ Relationship: _____Phone:_____

Name: _____ Relationship: _____Phone:_____

Name: _____ Relationship: _____Phone:_____

❑ **Please DO NOT discuss my Personal Health Information with anyone other than myself.**

## Pharmacy Information

**Retail Pharmacy Name:** _____ **Phone:** _____

**Address:** _____

**City:** _____ **State:** _____ **Zip Code:** _____

**Mail Order Company:** _____ **Phone:** _____

**Address:** _____

**City:** _____ **State:** _____ **Zip Code:** _____

**Patient Signature:** _____ **Date:**_____