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:**_____