OREGON EYE
PHYSICIANS & SURGEONS

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PATIENT INFORMATION

First Name:_____Middle Initial_____Last Name:_____

Patient SSN#_____--____--_____☐Male ☐Female Date of Birth_____/_____/_____ Age:_____

Mailing address:_____ City_____ State_____ Zip_____

Phone number: Home (_____)_____ Cell: (_____)_____ Work (_____)_____

Email Address:_____ (Required for Patient Portal)

Race:
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or other
- ☐ Hispanic
- ☐ White/Caucasian
- ☐ Decline to specify

Primary Insurance:_____

Insurance Policy Holder:_____ ____DOB: ___/___/_____

Secondary Insurance:_____

Insurance Policy Holder: _____DOB:___/___/_____

Preferred pharmacy:_____ Telephone: (_____)_____

I authorize my medical information to be released to:_____ Relationship:_____

Have we seen another member of your family? ☐ Yes ☐ No Name:_____

Who may we thank for referring you to our office?_____

In case of emergency, whom should we notify?
Name:_____ Phone Number:_____ Relationship:_____

Signature_____ Date:_____

Must be the guarantor and person who has decision-making authority for patient, if patient is a dependent.