OREGON EYE
PHYSICIANS & SURGEONS

Patient Information

First Name: _____ Middle Initial: _____ Last Name: _____

Patient SSN: _____-_____-_____ ☐ Female ☐ Male Date of Birth: _____/_____/_____ Age: _____

Mailing Address: _____ City: _____ State: _____ Zip code: _____

Phone Number: Home: _____ Cell: _____ Work: _____

Email Address: _____ (required for Patient Portal)

Preferred language: _____

Race: (select all that apply)

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic/Latino
- ☐ Native Hawaiian or other
- ☐ White/Caucasian
- ☐ Decline to Specify

Primary Insurance: _____

Insurance Policy Holder: _____ Policy Holder's DOB: _____

Secondary Insurance: _____

Insurance Policy Holder: _____ Policy Holder's DOB: _____

Preferred Pharmacy: _____ Phone Number: _____

In case of emergency, who should be notify? Name: _____

Phone Number: _____ Relationship: _____

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

Signed: _____ Date: _____

Printed Name: _____ DOB: _____

Relationship to patient (if signing as representative/guardian):_____