

Eye Physicians & Surgeons, Inc.

Meaningful Use Information

Due to changing healthcare laws, we are required to collect more patient demographic information.

FIRST NAME: _____ LAST NAME: _____

PREFERRED LANGUAGE: _____

RACE: (Circle One)

SMOKING STATUS: (Circle One)

American Indian or Alaska Native

Never Smoker

Asian

Current every day smoker. What year did you start? _____

Black or African American

Current some day smoker. What year did you start? _____

Native Hawaiian or Other Pacific Island

Former smoker. What year did you start? _____ Quit? _____

White

Unknown if ever smoked

Other

Decline to answer

Decline to Answer

Preferred Pharmacy: _____ Pharmacy Phone/Fax: _____

Pharmacy Address: _____

I agree that Eye Physicians and Surgeons may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payers for treatment purposes.

PATIENT PORTAL REGISTRATION

Registration to the portal provides you with online access to the office anytime and anywhere. You will be able to request appointments & refill prescriptions, access your medical records, securely message the staff and doctors, set up appointment reminders, and much more.

TO ACCESS THE PORTAL, please provide us with your email address.

EMAIL: _____

An email will be sent to you with directions on how to register for the portal. **The email you provided will be your user name.** When prompted enter the pin provided via email for your first log in.

TO OPT OUT OF THE PORTAL, please check the following box.

Keep in mind that if you require records you will have to pay a fee as outlined in our financial policy.

Patient Signature: _____ Date: _____