OMEG
OKLAHOMA MEDICAL EYE GROUP

# PATIENT DATA SHEET

PRINT Full Name:_____ Date of Birth: ____ /____ /_____ Age: ___

Address: _____ City: _____ State: _____ Zip: _____

Mobile Phone: (____)_____-_____ Home Phone: (____)_____-_____ Alt. Phone: (____)_____-_____

*Appointment reminders will be sent via text message. If you want to opt-out, please inform the front desk.

SS#: _____-____-_____ Driver's License #: _____ Marital Status: _____

Race: _____ Ethnicity: _____ Sex: ☐ M ☐ F Email: _____

Reason for your visit:

_____

If your visit is due to an accident, please provide the date of the accident and summary:

_____

If today is your 1st visit, how did you hear about OMEG?

_____

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Referring Doctor: _____ Optometrist: _____

Primary Care Physician: _____ Phone: (____)_____-_____ Last Visit: _____

Preferred Pharmacy Name/Address: _____ Phone: (____)_____-_____

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Emergency contact(s) we can call in case of an emergency &/or about your visit if necessary:

Name: _____ Relationship: _____ Phone: (____)_____-_____

Name: _____ Relationship: _____ Phone: (____)_____-_____

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Primary Insurance: _____ Secondary Insurance: _____

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Primary insured/responsible party: Name: _____

SS#: _____-_____-_____ Date of Birth: ____ /____ /_____ Relationship to the patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (_____)_____-_____ Alt Phone: (_____)_____-_____

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By signing below, I certify all information is accurate to my knowledge.
I have been provided Oklahoma Medical Eye Group's Patient Information Privacy Notice.

_____ _____

Patient Signature (or authorized representative) Date

Updated 07/19 KE