



Patient Name: _____

Patient Acct #: _____

Dear Patient: We are in the beginning stages of implementing a new electronic medical records (EMR) system that is now required by federal law. We take patient confidentiality very seriously. New Federal regulations regarding healthcare now require us to gather information that may be reported to the federal government at their request. The information that we are gathering will never be shared with any other organization or entity unless required by Federal regulation or mandate.

Please assist us in gathering this required information:

1. What Ethnicity do you consider yourself (patient) to be part of?

Hispanic or Latino

Declined To Answer

Non-Hispanic or Non-Latino

2. What Race do you consider yourself (patient) to be part of?

American Indian or Alaska Native

Native Hawaiian or Other Pacific Islander

Asian

White

Black or African American

Declined To Answer

3. What language is your primary preferred language?

English

Portuguese

Declined to Answer

French

Russian

Italian

Spanish

Japanese

4. What is the name and location of your primary choice for a retail pharmacy (i.e. At what pharmacy do you choose to fill your prescriptions?)

Name: _____

Street: _____ City: _____

Secondary (Mail Order): _____

5. What was the key reason(s) you chose our Practice for your eye care needs?

Family/Friend Referral Name: _____

Physician Referral Name: _____

Reputation/Experience of Doctor

Availability of Latest Eye care Technology

Practice Website

Print Advertisement

Online Doctor Review

Facility/Office Location

Social Media

Presentation/Wellness Fair/etc.

Other _____