Drs. Douglas and Victoria M. Weiss, Optometrists
www.weisseyes.com

We appreciate your assistance in helping us keep your information current in our records.

Name (print)____ Date __________________________

I acknowledge I have been informed about the updated ***Notice of Privacy Practices*** from Drs. Douglas and Victoria M. Weiss, Optometrists. A copy is available to me upon request.

Signature____

If signing as a personal representative, please describe the relationship to the patient and the source of authority to sign this form

Name ____ Relationship _________________________________

Communication Preferences: Please place a check in the box next to your preferred phone number

☐Home __________________________________ ☐Work ___________________________________

☐Cell phone______________________________ Email__________________________________

Communication Opt-In: Please indicate by checking boxes to indicate your communication preferences

	Home	Work	Cell	Email	Text Message	Mail
Appt Confirmations	☐	☐	☐	☐	☐	☐
Recall Reminders	☐	☐	☐	☐	☐	☐
Orders	☐	☐	☐	☐	☐	☐
Education Materials	☐	☐	☐	☐	☐	☐

Please choose a response for the following questions. Numerous studies document that racial and ethnic minorities often have less often and less frequent access to health care than non-minorities. Our practice is required to request the information below as part of state and federal governmental efforts to monitor and eliminate these disparities.

Race (please check all that apply)

___American Indian or Alaska Native

___Black or African American

___Native Hawaiian or Other Pacific Islander

___Decline to provide

___Asian

___White

___Other________________

Ethnicity

___Hispanic or Latino

___Not Hispanic or Latino

___Decline to provide

Language

____

___Decline to provide

We would request your specific permission to share your information about your care and/or financial matters with others. Please indicate the persons we may share your information with by **initialing each block**.

Name of Person	Relationship to Patient	Financial Information Only	Medical/Vision Information Only
I do not wish to share my information with another party ____________________(initial)			