Pullman Vision Source™

Patient Profile

Dr. **James** P. DeVleming

Today's Date: ______________

PATIENT INFORMATION

(Please Print ALL Information – Thank you!)

Name: ______________

Middle Initial: ________ **Date of Birth** ______________

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Other ❑ Widowed

Address: ______________

____

City / State: ______________ **Zip Code:** ________

Contact Phone Numbers:

Primary ( ) ______________ ❑ Home ❑ Work ❑ Cell

Secondary ( ) ______________ ❑ Home ❑ Work ❑ Cell

E-mail: ______________

(If over 18 yrs. of age)

Emergency Contact: Name: ______________

Phone: ______________ Relationship: ________

Sex: ❑ Male ❑ Female ❑ Undetermined

Social Security #: ______________

Primary Care Physician: ______________

Pharmacy: ______________

New Patients: Who can we thank for referring you?

____

The Federal Government now requires us to collect the following information (please choose only **ONE ANSWER** for each category):

Language: ❑ English ❑ Spanish ❑ Japanese ❑ French ❑ Russian ❑ Other

Race:
- ❑ All other races
- ❑ American Indian or Alaska Native
- ❑ Asian
- ❑ Black or African American
- ❑ Native Hawaiian or Other Pacific Islander
- ❑ White
- ❑ Decline to Answer

Ethnicity:
- ❑ Not Hispanic / Latino
- ❑ Hispanic/Latino

LEGALLY RESPONSIBLE (GUARANTOR) INFORMATION

❑ Same as Patient

Name: ______________

Address: ______________

____

City/ST: ______________ Zip Code: ________

Employer: ______________

Phone: ( ) ______________

Phone: ( ) ______________

Social Security # ______________

Date of Birth: ______________

INSURANCE INFORMATION

PRIMARY INSURANCE ❑ Same as Patient ❑ Same as Guarantor ❑ Other

Insured Party: ______________

Insured Phone: ______________

Social Security#: ______________

Date of Birth: ______________

Relationship to Primary: ______________

Company: ______________

Insured ID: ______________

Policy Group: ______________

SECONDARY INSURANCE ❑ Same as Patient ❑ Same as Guarantor ❑ Other

Insured Party: ______________

Insured Phone: ______________

Social Security#: ______________

Date of Birth: ______________

Relationship to Primary: ______________

Company: ______________

Insured ID: ______________

Policy Group: ______________