PULLMAN VISION SOURCE®

JAMES P. DEVLEMING, O.D. JENNA DEWALD, O.D.

PATIENT PROFILE

Today's date: _____

PATIENT INFORMATION

Name: _____

Preferred name: _____ Middle Initial: ____

Date of birth: _____

Sex ☐ Male ☐ Female ☐ Prefer not to disclose

Marital status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Other

Language ☐ English ☐ Spanish ☐ Japanese ☐ French ☐ Russian ☐ Other: _____

Ethnicity ☐ Hispanic/Latino ☐ Non-Hispanic/Latino

Dominant hand ☐ Right ☐ Left ☐ Ambidextrous

SSN: _____

Address: _____

_____

City: _____ State: _____ Zip: _____

Primary care physician: _____

Pharmacy: _____

Race ☐ Native American or Alaska native ☐ Asian ☐ Black or African American ☐ Caucasian ☐ Pacific Islander ☐ Decline to answer

Employment status ☐ Employed ☐ Unemployed ☐ Retired ☐ Student

Employer/School: _____ Occupation/Grade: _____

For new patients, how did you hear about our office?

☐ Referred by family or friend: _____ ☐ Other provider: _____

☐ Insurance company ☐ Internet search ☐ Radio ☐ Walk by ☐ Other: _____

CONTACT INFORMATION

Primary phone: (_____) _____ ☐ Cell ☐ Home ☐ Work

Secondary phone: (_____) _____ ☐ Cell ☐ Home ☐ Work

E-mail: _____

Emergency contact: _____

Phone: _____

Relationship: _____

Pullman Vision Source would like to know the best way to contact you with information regarding your upcoming appointments and any glasses or contact lens orders you may have. Please let us know the best way to notify you. Check all that apply:

- ☐ Text message
- ☐ E-mail
- ☐ Call – automated
- ☐ Call – manual
- ☐ Please send notifications regarding my appointments and orders to the following individual:

  Name: _____ Relationship: _____

  Contact method: _____

— PLEASE CONTINUE FILLING OUT ON THE BACK OF THIS PAGE —

LEGALLY RESPONSIBLE (GUARANTOR) INFORMATION ☐ Same as patient ☐ Same as emergency contact

Name: _____ Phone: _____

DOB: _____ SSN: _____ Relationship: _____

Address: _____

_____

City: _____ State: _____ Zip: _____

COMMUNICATION

By law, Pullman Vision Source cannot discuss any of your information with anyone other than you without your consent, including spouses and children over 18. Your consent is required to discuss ANY aspect of your eye health and relationship with us, including scheduling appointments, billing questions, and prescription information. By not specifying anything below, we will not discuss your eye health and information with anyone other than you. Please specify below the individual(s) who we can discuss your information with:

Guarantor	☐ All records	☐ Financial only
Emergency contact	☐ All records	☐ Financial only
Other	☐ All records	☐ Financial only

Name: _____ Relationship: _____

Phone(s): _____

PATIENT PORTAL

Our office staff will set you up with a patient portal. By not specifying an option below, Pullman Vision Source will only allow you to have access to your portal. The following people may be granted access to my patient portal:

- ☐ Guarantor
- ☐ Emergency contact
- ☐ Other (please list all that apply)

Name: _____ Relationship: _____

Phone(s): _____
