

James A. Williams Jr. OD and Shad L. Wheatley OD, PLLC

Welcome To Our Office

Welcome to the practice of James A. Williams Jr. OD and Shad L. Wheatley OD. Thank you for choosing us for your eyecare and eyewear needs. We appreciate the confidence you place in us in allowing us to serve you.

Please take a moment to complete the following information. Any information we already have on file will appear on this form. Please review all completed areas to ensure that the information we have is current and accurate. If you have any questions, please do not hesitate to ask.

Mr. Miss Mrs. Ms.

First Name _____		MI _____	Last Name _____	
Street Address _____		City _____	State _____	Zip _____
Social Security Number _____	Date of Birth _____	Home Phone - Include Area Code _____	Work Phone _____	
Email Address _____	Spouse or Parent(s) Name _____	Person Responsible for Account (Must sign below) _____		
Employer _____	Name Of Medical Doctor _____	Location Of Medical Doctor _____		

Primary Insurance Information

Secondary Insurance Information

Company name _____			
Address _____			
City _____	State _____	Zip _____	
M <input type="checkbox"/>	Insured's Name _____		
F <input type="checkbox"/>	Name _____		
Insured's ID Number _____			
Group Number _____			
Insured's Date of Birth _____			

Company name _____			
Address _____			
City _____	State _____	Zip _____	
M <input type="checkbox"/>	Insured's Name _____		
F <input type="checkbox"/>	Name _____		
Insured's ID Number _____			
Group Number _____			
Insured's Date of Birth _____			

Patient Relationship to Insured

Patient Relationship to Insured

Self Spouse Child Other

Self Spouse Child Other

Tell Us About Yourself So That We Can Better Meet Your Eyecare Needs

Do you have a backup pair of glasses? yes no
Do you currently wear contact lenses? yes no
Would you be interested in a trial of the latest in contact lens designs? yes no

Does night time glare bother you? yes no
Does sunlight bother you? yes no
Do you work on a computer? yes no
Would you like thinner, lighter lenses? yes no

Please list your hobbies: _____

Please list other members of your household: _____

How were you referred to our office? _____

Please Read and Sign:

In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and material are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks. Payment from my insurance is to be paid directly to JA WILLIAMS & SL WHEATLEY PLLC. I understand that Medicare will be billed as my primary insurance. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

Signature _____

Date _____