

Wills Eye Hospital/Clinic
Patient Assistance Questionnaire
Phone: 215-928-3460

Patient should complete

Are you a US Citizen or do you have a Green Card? Yes/No

Is your current legal address in Pennsylvania? Yes/No

Name: _____ Birth

Date: _____

Address: _____

Total annual household income:

Number of family members: _____

Department should complete

Please ask physician whether the patient needs care today because delay in treatment could cause permanent visual impairment. If yes, please ask him/her to state why and sign below.

Reason:

Physician Signature: _____

Date: _____