Leeds Family Eye Care, Inc.

Comprehensive Optometry
Jason B. Pulliam, O.D.

PATIENT INFORMATION

DR. _____ MR. _____ MRS. _____ MS. _____ MISS _____

PATIENT NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE NUMBERS: HOME_____ WORK_____CELL_____

PLACE OF EMPLOYMENT/SCHOOL_____OCCUPATION_____

SOCIAL SECURITY #_____DATE OF BIRTH_____

EMAIL ADDRESS_____

SPOUSE/PARENT NAME _____

SPOUSE/PARENT PHONE # _____

RESPONSIBLE PARTY INFORMATION

PERSON RESPONSIBLE FOR BILL_____

ADDRESS_____PHONE_____

MEDICAL INSURANCE _____POLICY #_____

VISION INSURANCE _____POLICY# _____

IF THE INSURED IS OTHER THAN PATIENT, PLEASE PROVIDE THE FOLLOWING:

INSURED'S SOCIAL SECURITY #_____ DATE OF BIRTH_____

INSURED'S EMPLOYER_____

OTHER INSURANCE INFORMATION: _____

VISION NEEDS QUESTIONNAIRE

	YES	NO
Do you currently wear glasses?	☐	☐
Do you plan to update your glasses?	☐	☐
Do you currently wear contacts?	☐	☐
-If yes, what brand? _____		
-If yes,are you satisfied with your vision and comfort?	☐	☐
-If yes, do you have a pair of back up glasses	☐	☐
-If no, are you interested in trying contacts?	☐	☐
Do you have prescription sunglasses?	☐	☐
Are you interested in thinner/lighter lenses?	☐	☐
Are you interested in LASIK?	☐	☐
Do you have problems with glare?	☐	☐
Do you suffer from eyestrain?	☐	☐
Do you suffer from afternoon headaches ?	☐	☐

NEW PATIENTS PLEASE FILL THIS OUT:

Who may we thank for referring you to our office?

Name of friend or relative _____

If not referred, how did you choose our office?

- ☐ Another Doctor _____
- ☐ Insurance List
- ☐ Saw our Sign/Building
- ☐ Newspaper/Radio
- ☐ Yellow Pages: Which Directory_____
- ☐ Our Website
- ☐ Another Website _____
- ☐ Other _____

(OVER)