Leeds Family Eye Care

Jason B. Pulliam, O.D. and Richard T. Williams, O.D.

PATIENT INFORMATION:

PATIENT NAME: _____PREFERRED NAME_____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE NUMBERS: HOME_____ WORK_____CELL_____

GENDER: □ M □ F

ETHNICITY: □ Not Hispanic or Latino □ Hispanic or Latino □ Other □ Declined to Specify

RACE: □ American Indian/Alaskan Native □ Asian □ African American □ Hispanic □ Native Hawaiian/Pacific Islander □ White □ Decline to Specify

PREFERRED LANGUAGE: _____

PLACE OF EMPLOYMENT/SCHOOL_____OCCUPATION_____

SOCIAL SECURITY #_____DATE OF BIRTH_____

EMAIL ADDRESS_____

MARITAL STATUS: □ Married □ Single □ Divorced □ Widowed

SPOUSE/GUARDIAN NAME and 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_____

PHARMACY/MEDICATION INSURANCE _____

Preferred Pharmacy: _____

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)