Barnes Crossing Vision Center
K.M. McCullough, O.D.
662-840-4624

New Patient ☐ Previous Patient ☐

Single ☐ Married ☐ Other ☐ Employed ☐

Not Employed ☐ Student ☐ Retired ☐

Name _____
(Last) (First) (Middle)

Name of Employer _____

Ethnicity: ☐ Caucasian ☐ African American
☐ Hispanic ☐ Other

Gender: ☐ Male ☐ Female

Social Security # _____

Address _____
Street City/State/Zip

Telephone _____
Home Work Cell

EMAIL _____

Appointment time _____ Date of Birth _____

Insurance Name _____

INSURANCE SIGNATURE ON FILE

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I request that payment of these benefits be made either to me or on my behalf to Kathryn McCullough, O.D. for any services and materials furnished. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Service and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in Item 9 of the CMS-1500 claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above.

_____ _____
Lifetime Patient Signature ***Date***

MEDICAL HISTORY QUESTIONNAIRE

Name _____ Date _____

Date of Birth _____ Date of last eye exam _____

List any medications you currently take (Rx and over-the-counter): _____

_____

Do you have allergies to any medications? YES NO
If YES, list the medications: _____

List all major illnesses (glaucoma, diabetes, high blood pressure, heart attack, etc.) or *injuries* (concussion, etc.):

_____

List any surgeries you have had (cataract, appendectomy): _____

Do you *currently* have any problems in the following areas? If YES, please provide additional information.

	YES	NO	Details
EYES (poor vision, eye pain, tearing, redness, etc.)			
GENERAL / CONSTITUTIONAL (fever, heart stroke, weight loss, weight gain, unusually tired)			
EARS, NOSE, THROAT (hard of hearing, stuffy nose, earache, cough, dry mouth, etc.)			
CADIOVASCULAR (high BP, racing pulse, etc.)			
RESPIRATORY (congestion, wheezing, short of breath, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)			I acknowledge that I received
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, yellow jaundice, etc.)			a copy of Dr. K.M. McCullough
FEMALES Are you pregnant? Nursing?			*Notice of Privacy Practices* today.
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)			Sign _____
SKIN (pimples, warts, growths, rash, etc.)			
NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD / LYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)			
ALLERGIC / IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)			

FAMILY HISTORY (Mother, Father, Grandparents, Sibling)

Has any member of your family had these diseases (circle all that apply) ? YES NO UNKNOWN

Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis

Other heritable disease:

SOCIAL HISTORY

Does your vision limit any activities of daily living (driving, reading, sports, work, etc.) ? YES NO

Have you ever had a blood transfusion? . . . . . YES NO

Do you drink alcohol? . . . . . YES NO If YES, how much? _____

Do you smoke? . . . . . YES NO If YES, how much? _____ How many years? _____

Physician's Signature _____ *Date* _____