Cullman Eye Specialists
601-B Graham Street, SW
Cullman, AL 35055
(256) 734-8514
Patient Information/ History

Name: ____ Nickname: ______________
Address: ______________________________City: _________ State: ____ Zip: _______
Cell #: ______________ Work #: _______________ Home #: ________________
Gender: Male ____ Female ____ Date of Birth: ____ /____/ _____ SS# _____ / _____ / _______
Marital Status: Single: ____ Married: ____ Divorced: ____ Widowed: _____
Employer or School: _______________________ Occupation or Grade: ___________________
Email: ____

Insurance Information

Medical Insurance

Insurance Company: ____
Policy Holder's Name: ______________________ DOB: ____ /_____ /_____
Relationship to Policy Holder: Self: _____ Spouse: _____ Child: _____
Contract # _______________________________ Group # ________________

Vision Insurance

Insurance Company: ____
Policy Holder's Name: ______________________ DOB: ____ /_____ /_____
Relationship to Policy Holder: Self: _____ Spouse: _____ Child: _____
Contract # or SS# of Policy Holder ____________________________________

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have read the summary of the NOTICE OF PRIVACY PRACTICES and know that I may receive a copy for my records if I choose. I understand that this office may use and disclose necessary personal health information to another party, to permit this office to perform its administrative duties, provide me with eye care services, process my insurance benefit claims, and communicate with me regarding vision care services provided by this office. I can be assured this office will not sell my personal health information to a third party.

PatientName___________________________Signature________________________Date__________

CONTACT LENS PATIENTS

The contact lens exam charges include a trial pair of contact lenses, instructions (if needed) on how to insert, remove, and care for lenses, and up to five follow-up visits within 60 days relating to the initial contact lens evaluation. Contact prescriptions will only be released after the fitting and evaluation period is successful. After 5 visits within 60 days, additional contact lens fitting charges will apply.

Patient/Guardian Signature____ Date________________

FINANCIAL RESPONSIBILITY

In the event that my insurance plan determines that I am not eligible at the time of services or that I am only eligible for a reduced level of coverage, I agree to be financially responsible for any charges incurred that are not covered by my insurance plan.

Patient/Guardian Signature_____________________________________ Date__________________

Medical History

Primary Care Physician: ____________________________ Date of last physical exam: ___________

Current Medications: ____

Allergies to Medications: ____

Major Surgeries or Hospitalizations: ____

Are you Pregnant? __________ Nursing? __________ Due date if pregnant? ____________________

Date of Last Eye Exam: ______________________ Doctor Seen: _____________________________

Do you wear glasses? _____ if so how old is current pair? _____ Circle: Bifocals/Trifocals/Progressive

Do you wear contacts? _____ Brand? _________________________ Do you sleep in them? _______

MEDICAL/OCULAR HISTORY

Do you or any of your family members have a history of the listed conditions, living or deceased?

Condition		
Blindness	☐ yes ☐ no	Relationship: ___________________________________
Cataracts	☐ yes ☐ no	Relationship: ___________________________________
Glaucoma	☐ yes ☐ no	Relationship: ___________________________________
MacularDegeneration	☐ yes ☐ no	Relationship: ___________________________________
Retinal Detachment	☐ yes ☐ no	Relationship: ___________________________________
Lazy/Crossed eye	☐ yes ☐ no	Relationship: ___________________________________
Diabetes	☐ yes ☐ no	Relationship: ___________________________________
High Blood Pressure	☐ yes ☐ no	Relationship: ___________________________________
Lupus	☐ yes ☐ no	Relationship: ___________________________________
Thyroid	☐ yes ☐ no	Relationship: ___________________________________

Other: ____

REVIEW OF SYSTEMS—Are you currently experiencing any of the following problems?

ALLERGIC ☐ yes ☐ no

VASCULAR/CARDIOVASCULAR
- Stroke ☐ yes ☐ no
- High blood pressure ☐ yes ☐ no
- Vascular disease ☐ yes ☐ no

CONSTITUTIONAL
- Fever, Weight loss/gain ☐ yes ☐ no
- Weakness/Dizziness ☐ yes ☐ no

ENDOCRINE
- Thyroid/other glands ☐ yes ☐ no
- Diabetes ☐ yes ☐ no

GASTROINTESTINAL
- Acid Reflux ☐ yes ☐ no
- Other GI Disorder ☐ yes ☐ no

GENITOURINARY
- Genitals/kidneys/bladder ☐ yes ☐ no
- Sexually transmitted diseases ☐ yes ☐ no

EARS, NOSE, MOUTH THROAT
- Sinusitis ☐ yes ☐ no
- Dental Disease ☐ yes ☐ no
- Ear Infections ☐ yes ☐ no

LYMPHATIC/HEMATOLOGIC
- Anemia ☐ yes ☐ no
- Bleeding problems ☐ yes ☐ no

IMMUNOLOGIC
- HIV ☐ yes ☐ no
- Other immune problems ☐ yes ☐ no

INTEGUMENTARY (skin)
- Eczema yes no

BONES/JOINTS/MUSCLES
- Arthritis ☐ yes ☐ no
- Scoliosis ☐ yes ☐ no

Myesthenia Gravis ☐ yes ☐ no

NEUROLOGICAL
- Headaches ☐ yes ☐ no
- Migraines ☐ yes ☐ no
- Seizures ☐ yes ☐ no

PSYCHIATRIC ☐ yes ☐ no

RESPIRATORY
- Asthma ☐ yes ☐ no
- Chronic bronchitis ☐ yes ☐ no
- COPD ☐ yes ☐ no

If you answered yes to any of the above or have other unlisted conditions, please explain:

____

____

Other

Hobbies: _____________________________________ Computer Use: _______ Hours per day: _____

Do you use tobacco? ________ If yes: What type/amount/how long? ____________________________

Do you drink alcohol? _______ If yes: What type/amount/how long? ____________________________

Do you use illegal drugs? _____ If yes: What type/amount/how long? ___________________________