WELCOME

Thank you for choosing Dr. McDevitt for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you have placed in us. Please take a moment to complete the following information. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help you.

PATIENT INFORMATION **DATE:**____________________

____Mr. ____Mrs. ____Ms. ____Miss ____Dr. ____Male ____Female

First Name ______ MI ______ Last Name ______

Street Address ______ City ______ State ______ Zip ______

Social Security Number ______ Date of Birth ______ Home Phone ( ) ______ Work Phone ( ) ______

Email Address ______ Occupation ______ Employer ______

If you are a student, name of school or college : ____________________

Spouse or Parent(s) Name ______ Person Responsible for Account (must sign below) ______

Whom may we thank for referring you to our office? ____________________

What is the main reason for today's exam ?____________________ Date of last exam____________

Primary Insurance Information

Name of Primary Insurance ______ Insured's Name ______

Insured's ID Number ______ Group Number ______ Insured's Date of Birth ______

Patient Relationship to Insured ___Self___Spouse___Child

Patient Status___Single___Married___Other___Full Time Student___Part Time Student___Employed

Please Read:

In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. We do not guarantee the accuracy of benefit information given to us by insurance companies!!! Accounts 90 days old may be subject to collection fees. There will be a service charge on all returned checks. I authorize any holder of medical information about me, to release to the health care financing administration and its agents any information needed to determine these benefits or the benefits payable for related services. I also acknowledge receipt of Dr. McDevitt's Notice of Privacy Practices.

Signature________________________________ Date____________________

Name_______________

Date_______________

PATIENT HISTORY AND INFORMATION

VISUAL HISTORY

Do you use a computer ?____Yes____No How many hours/day ?_____ Distance from computer_____

Do you drive ?____Yes____No Do you have glare problems ? ____Yes____No

Do you have problems with night vision ?____Yes____No

SPECTACLE LENS HISTORY

Do you currently wear glasses ?____Yes____No Since_________

Type of glasses

___Single Vision___Bifocals___Trifocals___Progessive___Back-up glasses

Have you had trouble in the past with glasses ?____Yes____No ______________________________

Do you wear sunglasses ?____Yes____No Are they your current prescription ?____Yes____No

---

CONTACT LENS HISTORY

Do you currently wear contact lenses ?____Yes____No Since_____________

Have you ever tried to wear contact lenses ?____Yes____No Reason for stopping_______________

Are you interested in trying contact lenses at this time ?____Yes____No

Type and brand of contact lenses worn ____

SOCIAL HISTORY

Do you use nutritional supplements (vitamins etc) ?____Yes____No List_______________________

Do you engage in regular exercise ?____Yes____No

Do you drink alcohol ? If yes, how much/often:___No___Occasional___1 per day___2-3/day___4+/day

Do you smoke ? If yes, how much/often:___No___Occasional___1/2pack/day___1 pack/day___1+packs

Name________________

Date________________

MEDICAL HISTORY QUESTIONNAIRE

EYE HISTORY

	YES	NO		YES	NO
Blurred Vision	___	___	Headaches	___	___
Distorted Vision (halos)	___	___	Burning	___	___
Double Vision	___	___	Dryness	___	___
Floaters	___	___	Redness	___	___
Fluctuating Vision	___	___	Itching	___	___
Loss of Vision	___	___	Light Sensitive	___	___
Loss of Side Vision	___	___	Tearing	___	___
Lazy Eye	___	___	Mucous Discharge	___	___
Crossed Eye	___	___	Eye Pain or Soreness	___	___
Foreign Body Sensation	___	___	Infection of Eye or Lid	___	___

FAMILY HISTORY

	YES	NO		YES	NO
Blindness	___	___	Allergies	___	___
Cataract(s)	___	___	Arthritis	___	___
Color Blindness	___	___	Cancer	___	___
Glaucoma	___	___	Diabetes	___	___
Lazy Eye	___	___	Heart Disease	___	___
Macular Degeneration	___	___	High Blood Pressure	___	___
Retinal Detachment	___	___	Kidney Disease	___	___
Others	___	___	Lupus	___	___
			Stroke	___	___

GENERAL HEALTH CONDITION

	YES	NO		YES	NO
Fever	___	___	Kidney	___	___
Weight Loss	___	___	Muscles,Bones,Joints	___	___
Ear,Nose,Throat	___	___	Skin	___	___
Respiratory(Asthma)	___	___	Neurological(MS)	___	___
High Blood Pressure	___	___	Allergic/Immunologic	___	___
Gastrointestinal Urinary	___	___	Blood/Lymph(Cholesterol)	___	___
Psychiatric	___	___	Diabetes,Thyroid	___	___
Hepatitis	___	___	Anxiety,Depression,Insomni	___	___

Name________________

Date_________________

GENERAL HEALTH CONDITION(CONT)

Past injuries or illnesses:____

Past Surgeries:____

Are you pregnant ?____Yes____No____Possibly

Current medications: ____

____

Medicines that cause reactions or sensitivities: ____

Specific Allergies:____

What is the name of your family doctor ?____

THANK YOU !!