Eye Vermont
100 Dorset Street, Suite 25
South Burlington, VT 05403

Patient Name: _____ Birth Date: ____/____/_____ Male / Female

Name of Parent or Guardian for Patients under 18:_____

Billing Address: _____ City: _____ State: _____ Zip: _____

Home Phone Number: _____ Mobile: _____ Work: _____

Social Security Number: _____ Marital Status: S M CU D W

E-Mail: _____ (only used to confirm future appointments)

Insurance Information:

Primary Medical Insurance: _____ Identification Number: _____

Primary Vision Insurance: _____ Identification Number: _____

Social History:

This Information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

Do you use any of the following:	Yes	No	If yes, type / amount / how long
Tobacco Products ……..	☐	☐	_____
Alcohol……..……	☐	☐	_____
Illegal Drugs…….	☐	☐	_____

Notice of Privacy Practices at Eye Vermont

I hereby acknowledge that I have been presented with a copy of Eye Vermont Notice of Privacy Practice.

_____ Date: _____

Patient Signature

_____

Patient Name, please print

Vincent J. DeVita, O.D., F.A.A.O.
Joseph P. O'Brien, O.D., F.A.A.O.

Julie A. DeVita, O.D.,F.A.A.O.
Jennifer R. DeVita,O.D., F.A.A.O.

Medical Information:

Current Medical Doctor (PCP): _____ Last Medical Exam: _____

Do you have any allergies to medications? Yes / No

If Yes, please explain _____

List any medications you take, including over the counter _____

_____

Are you Pregnant and / or nursing? Yes / No

Ocular History:

Eye Surgeries: _____ When: _____ Surgeon: _____

Eye Surgeries: _____ When: _____ Surgeon: _____

Are you currently or have you ever been diagnosed with any of the following *ocular* conditions?

	Yes	No	Not sure
Crossed Eye / Lazy Eye……	☐	☐	☐
Glaucoma……	☐	☐	☐
Retinal Detachment……	☐	☐	☐
Macular Degeneration……	☐	☐	☐

Other: _____

Are you currently or have you ever been diagnosed with any of the following *medical* conditions?

	Yes	No	Not sure
Headaches / Migraines……..	☐	☐	☐
Brain Injury / Stroke / Neuro……..	☐	☐	☐
Seizures……	☐	☐	☐
Asthma / Emphysema……	☐	☐	☐
Allergies / Hay Fever……..	☐	☐	☐
Thyroid / Other Gland…….……	☐	☐	☐
Arthritis / Muscle……..……	☐	☐	☐
Vascular / High Blood Pressure……	☐	☐	☐
Anemia / Bleeding Problems…….	☐	☐	☐
Kidney / Bladder……..	☐	☐	☐
Recent Fever / Changes in Weight…..	☐	☐	☐
Skin……	☐	☐	☐
Psychiatric……..……..	☐	☐	☐
Cancer……..…….	☐	☐	☐

If yes, Type: _____ Treatment: _____

Diabetes……	☐	☐	☐

If yes, Type: _____ Year diagnosed: _____ Last A1c: _____%

Family History:	Yes	No	Not sure	Relationship to patient
Glaucoma…….	☐	☐	☐	_____
Macular Degeneration……	☐	☐	☐	_____
Retinal Detachment……	☐	☐	☐	_____
Diabetes……	☐	☐	☐	_____

Other: _____

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