Dr. Donald J. Seiler
Optometric Physician

Summit Eye & Optical
323 Springfield Ave, Summit, NJ 07901

PATIENT INFORMATION

Please print – complete both sides

Name	(Last) (First)			Date	
Address	(Street) (City) (State) (Zip Code)				
Home Phone			Work/Cell phone		
Email					
Age		Date of Birth		S.S.#:	
Occupation		School/Employer			
Name of Parent or Spouse					
1st Visit to this office?	Yes No				
How did you hear about us?	Previous Pt Google Insurance Friend/Family Others				
Approximate Date of Last Eye Exam					
Do you plan to purchase eyewear or contact lens at our store today?				Yes No	

Do you wear glasses now?	Yes =>	How old is the prescription? years	
	No		
Are you interested in wearing contact lens ?		Yes No	
Do you wear contacts now?	Yes		
	No =>	a) Why did you quit ?	b) Never tried
Do you feel a change is needed in your prescription			
	1) To see ***distant*** object more clearly	Yes No	
	2) To see ***near*** objects more clearly	Yes No	
Did you have lasik surgery? Yes No			

Medical History

What medications are you presently taking?	
What are they for ?	
Are you allergic to any medications? No Yes (Pls list:)	
Do you presently take any hormones (including birth control pills)?	Yes No
Are you allergic to tea tree oil? Yes No	
When was your last medical exam? Any abnormalities reported from this exam?	

Please <u>circle</u> any of the following that apply to you (past or present)		
Blurred Vision	Eyes tear frequently	Spots in your Vision
Squinting	Sensitivity to light	Itching or Burning Eyes
Double Vision	Frequent Red Eye	Eye Fatigue or Strain
Seeing Flashes of Light	Excessive Blinking	Glaucoma (high eye pressure)
Headaches	Eye or Head Injuries	Macular Degeneration
Heart Problems	High Blood Pressure	Previous Eye Disease/Infection/Surgery
Thyroid Problems	Allergies	Diabetes
Sinus Trouble	Asthma	HIV
Blindness	Tuberculosis	Skin Conditions
Cataract	Covid-19	***None of the above***
Others:		

Initial ______________________ ***(Please turn over)***

Family Health History – Has anyone in your family had (Pls circle)

Heart Disease	Blindness	Diabetes
Glaucoma	Other Eye diseases	Macular Degeneration
Others:	**None of the Above**	

Are you a smoker? Yes or No

Lifestyle Questionnaire

Which of the following hobbies or activities do you participate in? (Circle all that apply)			
Auto repair	Billing	Book keeping	Boating/Water Sports
Bowling	Competitive sports	Computer	Drawing
Diving	Exercise	Fishing	Golf
Home repairs	Hunting/shooting	Landscaping/Gardening	Musical instrument
Lacrosse	Baseball	Hockey/Field Hockey	Football
Basketball	Soccer	Painting	Pilot
Racquetball	Reading	Sewing/arts/crafts	Snow sports
Tennis	Watching TV	Welding	Woodwork
Cycling	Other: ________________________		
Which of the following do you experience on a regular basis? (Circle all that apply)			
Artificial lighting	Close up work	Computer work	Natural lighting
Paper work	Reading	Potential eye hazards	Others:_______________________
Do your eyes seem bothered by glare from any of the following? (Circle all that apply)			
Car headlights	Computer monitor	Fluorescent lights	Night driving
Sunshine	Traffic lights	Other: _______________________________	

Patient Acknowledgement – Notice of Privacy Practices

I have read the Notice of Privacy Practices written in plain language. The Notice provides in detail the use and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise those rights, and the practices' legal duties with respect to my information. I understand this practice reserves the right to change the terms of its' Privacy Practices and make changes regarding all protected health information generated or controlled by this practice. I may request a copy of the practice's current Notice of Privacy Practices at any time.

Signature ____ Date __________/__________/________

Relationship to Patient ____

Agreement Regarding Insurance Payments

I certify that the insurance information provided by me is accurate. I authorize the use of this information in helping me obtain payment for the services provided to me. I authorize payment directly to my doctor. A copy of the authorization may be used in place of the original.

I understand that the accuracy of this information is my responsibility. I also acknowledge that all fees for services and materials provided to me are my responsibility. I agree to pay all fees for services or materials should my insurance company reject the claim for any reason.

Signature: ____ Date __________/__________/________

12/2025