Dr. Donald J. Seiler
Optometric Physician

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

PATIENT INFORMATION

(Please complete & bring to your appointment. Thank you!)

Name	*(Last Name)* *(First Name)*			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?	☐ Return patient ☐ Family ☐ Friend, Name ☒ Internet ☐ Insurance/Vision Plan				
Approximate Date of Last Eye Exam					
What is the primary reason of your visit today?	Medical ☐ Vision ☐				
Do you plan to purchase eyewear or contact lens at our store today?	Yes ◯ No ◯				

Do you wear glasses now? Yes ◯ No ◯ →	How old is the prescription? years
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?
Do you presently take any hormones (including birth control pills)? Yes ◯ No ◯
When was your last medical exam? Any abnormalities reported from this exam?

Please <u>check</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
☐ **None of the above**		

Initial _____

(Please go to next page)

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

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

Are you a smoker? **Yes** ◯ **No** ◯ (Please check)

Lifestyle Questionnaire

Which of the following hobbies or activities do you participate in? (Check 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? (Check 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? (Check 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 : ☐ Self ☐ Parent/Guardian Name (Print): _____

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 _____

Relationship to Patient: ☐ Self ☐ Parent/Guardian Name (Print): _____

(Pls fill in the form then email to summiteyeoptical@gmail.com or fax to (908)918-0109 or print out & bring to your appointment. Thank you!)