VISION SOURCE® OF MT. OLIVE

MICHAEL J. SIEGEL, O.D. LIC#OA5118

135 Rt. 46 E., Unit E, Paramount Plaza * Budd Lake, NJ 07828 * 855-948-2020

WELCOME TO OUR OFFICE:

Today's Date:

Mr._____ Mrs._____ Ms._____ Miss_____ Dr.____
First:_____ Last:_____ MI:_____
Date of Birth:___/___/_____ Age____ Sex M F
Street:_____
City:_____State:____Zip code:_____
Home number:_____
Work number:_____Cell:_____
Preferred number for contact? H W C
Email address:_____
Social Security number:_____
Employer:_____
Occupation:_____
Emergency contact:
Name:_____Phone:_____
Relationship to contact:_____
Is this your first visit to our office?_____
Who can we thank for referring you to our office today?
_____
If you were not referred, how did you hear about our office?
_____
Please tell us why you are here today?
☐ Exam ☐ Glasses ☐ Contacts ☐ Infection or injury
☐ Medical problem ☐ Laser Vision Correction
☐ Other:_____

Medical Insurance : Policy Number:
_____
Subscriber:_____
Subscriber Social Security #_____
Subscriber Date of birth_____

Vision Insurance:_____
Subscriber:_____
Subscriber Social Security #_____
Subscriber Date of birth_____

Name of family physician_____
Address_____
Last visit_____

MEDICAL HISTORY:

Please circle all that apply to let us help you better:

EYE HISTORY:

headaches	glare light sensitivity	tired eyes
eye infection	excessive tearing/watering	redness
lazy eye	sandy or gritty feeling	itching
crossed eyes	foreign body sensation	dryness
loss of vision	retinal detachment	burning
double vision	diabetic retinopathy	glaucoma
color blindness	macular degeneration	cataract(s)
floaters	blurred distance vision	stye
flashes	blurred near vision	eye pain
other:		

GENERAL HEALTH:

Kidney	Muscles, bones, joints	Neurological
Endocrine	Ears, nose and throat	Psychiatric
Skin	Respiratory (asthma)	Diabetes
Allergic	Cardiovascular disease	Thyroid
Arthritis	High blood pressure	Blood/lymph
Stroke	Genital/urinary/bladder	AIDS/HIV
Cancer	High Cholesterol	Other:

FAMILY EYE AND MEDICAL HISTORY:

Blindness	Cataract	Glaucoma	Cancer
Diabetes	Macular Degeneration		Heart Disease
Arthritis	High blood pressure		Kidney

List all medications and vitamins and/or birth control pills
_____
_____
_____
Allergies to medications?_____
_____
Date of last eye exam?_____
Doctor?_____
Do you currently wear contacts?_____
If NO - are you interested?_____
Solution used_____

There is a **$55** fee to evaluate the fit of your current contacts
This fee is not usually covered by your managed care plans.
I want my current contacts evaluated:_____
please initial here