NEW JERSEY EYE CARE   NEW JERSEY CONTACT LENSES

Vince McGlone, O.D.
Heather Deeble, O.D.

Please make any changes to your name and address:

Name:____
Address:____
____
Tel# (H):____
Tel# (W):____
E-mail:____

Primary Care Physician name and address:

____
____
____

PCP phone:____________________________
PCP fax:______________________________
Medications:

Primary Insurance:
Secondary Insurance:
Medicare? Y N
ID or MC#:____________________________

1) Do you feel any changes in your vision?	Yes □	No □
2) Do you have trouble seeing near or far?	Yes □	No □
3) Do you experience headaches/dizziness?	Yes □	No □
4) Do you have any other health problems?	Yes □	No □

Please list:

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5) Have you had any changes in our medical history since your last visit? Explain

____

6) Do you have any allergies? Yes □ No □
Please list:

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7) Do you have spare contact lenses? Yes □ No □

8) When is the last time you had your eyeglasses replaced?__________________

Have you considered Laser Vision correction surgery?	Yes □	No □
Would you like the doctor to discuss your options?	Yes □	No □

Check Yearly. See Clearly.™