Total Vision Eye Care

New Patient Intake Form Adult 17+

Updated May 2023

General Information

Name:_____ DOB:_____

Address:_____ Phone:_____

Email Address:_____

Approximate Date of Last Eye Exam:_____ Occupation:_____

Family Doctor:_____ Are you pregnant or nursing: Yes __ No __ N/A __

Eye Health, Medical Health, Family History

Your Medical History (current or previous) check all that apply:

No Problems ___ Amblyopia (lazy eye) ___ Cataracts ___ Corneal Disease ___ Diabetes ___

Glaucoma ___ Peripheral Vision Defects ___ Retinal Disease ___ Strabismus (eye turn) ___

List *any* eye surgeries or injuries:_____

List *any* medical conditions:_____

List your current medications:_____

List *any* medicine allergies:_____

List *any* other allergies:_____

List any family eye history:_____

Current Vision & Eye Care Needs

What is the **main reason** for your visit:_____

Check off **any troubles** you are having (with your glasses on; if applicable):

Blurry Distance Vision ___ Blurry Near Vision ___ Eye Strain ___ Double Vision ___ Dry Eyes ___

Burning/Gritty Feeling ___ Soreness or Pain ___ Headaches ___ Floaters ___ Redness ___

Light Sensitivity ___ Flashes of Light ___ Itchiness ___ Poor Night Vision ___ Watering Eyes ___

Other (explain) _____

- **CONSENT FOR TREATMENT**: I/We hereby authorize Total Vision Eye Care to administer diagnostic and medical procedures as may be necessary for proper ocular health care.
- **OFFICE POLICY ON PAYMENT:** I understand that I am responsible for payment of all charges. As a courtesy, my insurance may be billed for me. It is my responsibility to pay any deductible, copay or any other balance not paid by my insurance company at the time of billing. I authorize insurance benefits to be paid directly to the provider, if I request it.
- **CONSENT FOR EMAIL COMMUNICATION:** I consent to Total Vision Eye Care sending me information about Total Vision Eye Care by e-mail and other electronic communications. I understand I can withdraw my consent at any time by contacting Total Vision Eye Care at J2-308 Taunton Rd. E., Whitby, ON, L1R 0H4, 905-620-0660. My email will not be used for marketing unless I request it, and will not be provided to a third party.
- **CANCELLATION POLICY:** I agree to provide 24 hours notice for any appointment cancellation. I understand that if I do not, I will be required to pay a rebooking fee before being able to book any household appointments. The cost will be $50.00 **or** the full fee of the missed appointment.

Patient Signature:_____ Date:_____