WELCOME TO OUR OFFICE

General Information:

Name: ______________________________________ Phone number:__________________________ DOB:______________________
Email:______________________________________ Date of Last Eye Exam:___________________
Family Doctor:_________________________________ Date of Last Medical Exam:________________ Occupation:_________________________
If female, are you pregnant or nursing? • **Y** • **N** If pregnant, how many weeks along? __________

How did you hear about our office?

• Sign on office • Google/Online Search • Social Media • Newspaper • Referred by (name) ____________________ • Other ______________________

What is your preferred method of contact?

• Home **Phone_______ • Cell Phone_______ • Work Phone_______ • Email_______ •Text message_______**

Please check here if you would like to receive information regarding in-office promotions _______

Eye, Health and Family History:

FAMILY HISTORY

Has anyone in your family been diagnosed with any of the following:
(circle all that apply)

- **No problems**
- **Diabetes**
- **High blood pressure**
- **Cancer**
- **Glaucoma**
- **Amblyopia (lazy eye)**
- **Strabismus (eye turn)**
- **Cataracts**
- **Macular degeneration**

CURRENT VISION

Glasses: Do you currently wear glasses? • **Y** • **N** *if yes, answer the questions below; if no, continue to contact lenses section:*
What type of lenses are in your glasses? **• Single vision • Bifocal • Trifocal • Progressive**

Contact Lenses: Do you currently wear contact lenses? **• Y • N** *if yes, answer the questions below; if no, continue to next section:*
What type of contact lenses do you wear? **• Soft • Rigid**
What is the manufacturer/model of your contact lenses? ____________________________________
What are the powers of your contact lenses (if you know)? ____________________________________
How old are your current contact lenses? ______ **Days / Weeks / Months / Years**
How often do you replace your contact lenses? **• Daily • Weekly • 2 weeks • Monthly • 3 months • Annually**
What solutions do you use to care for contact lenses? **• Renu • Optifree • Clear Care • Boston • Biotrue • Peroxiclear •Complete • Sensitive Eyes • Other: ___________**

List any previous eye surgeries and/or eye injuries, if applicable:____

List any medical conditions you have: ____

List current medications: ____

List any medicine allergies: ____

List any other allergies: ____

---Please see other side --->

Vision and Eye Care Needs:

Do you have trouble with any of the following?

_______ Blurry Distance Vision _______ Poor night vision _______ Eyestrain _______ Glare or reflections

_______ Blurry near vision _______ Headaches _______ Double Vision _______ Trouble reading/learning

_______ Itchiness _______ Burning _______ Watering eyes _______ Dry eyes

_______ Floaters _______ Flashes of light _______ Gritty feeling _______ Redness

_______ Soreness or pain _______ Light sensitivity

Other (explain):____

Do you spend time at a computer ?.................................... YES NO If yes, how many hrs/day? _______

Are you interested in newer contact lens technology? ... YES NO

Do you want information on thinner / lighter lenses? .... YES NO

Do you want information on LASIK vision surgery?.......... YES NO

Do you spend a lot of time outdoors?................................... YES NO

Do you have glasses that filter 100% of UV light?...............YES NO

What was the main reason for your visit today : ____

Please list your sporting activities / hobbies: ____

Eye Care For Your Family

❏ **not applicable**

We would like to ensure that all of your family members are also receiving the highest quality eye care available. To help us make the appropriate recommendation, please list the names and ages of any children that are still living at home. Thank you very much.

Name	Age	Date of last known eye examination

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Total Vision Eye Care to release any medical or incidental information that may be necessary for medical benefit of in processing applications for submissions to my insurance company.
CONSENT FOR TREATMENT: I/We hereby authorize Total Vision Eye Care to administer diagnostic and medical procedures as may be necessary for proper 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. 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 publications containing announcements, promotions and other information about Total Vision Eye Care and their products and services 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.

SIGNATURE: ____DATE: ____________________________