WELCOME TO OUR OFFICE - CHILD

General Information:

Name: _____ Home Phone #::_____ Cell #::_____
Parent Email:_____ DOB:_____
Date of Last Eye Exam:_____ Date of Last Medical Exam:_____
Name of Parent or Guardian:_____ Grade at School:_____
Family Doctor:_____OHIP#:_____ Version Code:____ ____

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_____ • No Preference_____**

Please check here if you would like to receive information regarding in-office promotions (approx 4/year) _____

Eye, Health and Family History:

FAMILY HISTORY	CURRENT VISION
Has anyone in your family been diagnosed with any of the following: (circle all that apply) **• No Problems** **• High myopia** **• Diabetes** **• High blood pressure** **• Cancer** **• Glaucoma** **• Amblyopia (lazy eye)** **• Strabismus (eye turn)** **• Cataracts** **• Macular degeneration**	**Glasses**: Do you currently wear glasses? **• Y • N** If yes, what do you use your glasses for? **• Distance • Reading/Computer • I wear them all of the time** If yes, do you currently have a back-up pair? **• Y • N** **Vision Therapy:** Have you ever had to do any "eye exercises"? **• Y • N** **Patching:** Have you ever had to wear a patch over one eye? **• Y • N**

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/on a tablet ?..... YES NO If yes, how many hrs/day? _____

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

Do you have sunglasses 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 other 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 (parent or guardian): _____DATE: _____