WELCOME TO OUR OFFICE

General Information:

Name: _____ DOB:_____
Parent's Email:_____ Phone number:_____
Family Doctor:_____ Date of Last Medical Exam:_____
Name of Parent(s)/ Guardian(s):_____ Is this a first eye examination?_____

How did you hear about our office?

• Sign on office • Google/Online Search • Social Media • Shoppe's Newsletter • Flyer
• 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 an email regarding in-office promotions (approx 2-4/year) _____

Eye, Health and Family History:

CHILD'S EYES

Is your child able to recognize you from across the room? Y N
Is your child able to see small objects (ie. size of a pea)? Y N
Does your child's eye turn in or turn out? Y N
Does your child's eye water excessively? Y N

PRENATAL/POSTPARTUM HISTORY

Were there any complications during pregnancy? Y N
Were there any complications during delivery? Y N
Were forcepts used during delievery? Y N
Was your baby born prematurely? Y N If Yes, at week _____

List any previous eye surgeries and/or eye injuries:_____

List any medical conditions your child has: _____

List current medications: _____

List any medicine allergies: _____

List any other allergies: _____

----------**Please see other side** ---------->

Vision and Eye Care Needs:

What was the main reason for your visit today :

- ❑ **Regular exam - I don't have any concerns**
- ❑ **I am concerned about:**_____

FAMILY HISTORY

Have any of your child's direct family members been diagnosed with any of the following:

(check all that apply and indicate the relationship of the person with the condition to your child)

- ❑ **• No Problems**
- ❑ **• High myopia** _____
- ❑ **• Diabetes** _____
- ❑ **• High blood pressure** _____
- ❑ **• Cancer** _____
- ❑ **• Glaucoma** _____
- ❑ **• Amblyopia (lazy eye)** _____
- ❑ **• Strabismus (eye turn)** _____
- ❑ **• Cataracts** _____
- ❑ **• Macular degeneration** _____

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: _____