TOTAL VISION EYE CARE - INFANT WELCOME

General Information:

Child Name: _____ OHIP# _____ _____ _____ Version Code: ___ ___
Address: _____ DOB: _____
Name of Parent/Guardian: _____ Family Doctor: _____
Is this a first eye examination?: ___ Yes ___ No DOB: _____ Date of Last Medical Exam: _____
Parent/Guardian Contact - Email: _____ Home#: (____)_____ Cell#: (____)_____

Check how you heard about our office.

☐ Office Sign ☐ Online Search ☐ Social Media ☐ Referred by (name)_____ Other _____

Check off 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:

INFANT EYE HEALTH

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** ☐ **Not Sure**
Does your child's eye water excessively? ☐ **Y** ☐ **N** ☐ **Not Sure**

PRENATAL/POSTPARTUM HISTORY

Were there any complications during pregnancy? ☐ **Y** ☐ **N** ☐ **Not Sure**
Were there any complications during delivery? ☐ **Y** ☐ **N** ☐ **Not Sure**
Were forceps used during delivery? ☐ **Y** ☐ **N** ☐ **Not Sure**
Was your baby born prematurely? ☐ **Y** ☐ **N** ☐ **If yes, how many weeks?** ☐

List any eye surgeries or injuries (or write none): _____
List any medical conditions (or write none): _____
List current medications (or write none): _____
List any medicine allergies (or write none): _____
List any other allergies (or write none): _____

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Vision and Eye Care Needs:

What was the main reason for the visit today :

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

FAMILY HISTORY

Mark **Maternal** or **Paternal** for all applicable conditions - up to child's grandparents

- ☐ No Problems
- ☐ Diabetes: _____
- ☐ High Myopia: _____
- ☐ High Blood Pressure: _____
- ☐ Cancer: _____
- ☐ Glaucoma: _____
- ☐ Amblyopia (lazy eye): _____
- ☐ Strabismus (eye turn): _____
- ☐ Cataracts: _____
- ☐ Macular Degeneration: _____

Eye Care For Your Family

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 or check Not Applicable. Thank you very much.

☐ **Not applicable**

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 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. 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.

Updated October 2021

SIGNATURE: _____ DATE: _____