TOTAL VISION EYE CARE - ADULT WELCOME (17+)

Please fill out *all* sections completely.

General Information:

Name: _____ OHIP# _____ Version Code: _____
Address: _____ Email Address: _____
Home #: _____ Cell #:_____ DOB: _____
Date of Last Eye Exam: _____ Date of Last Medical Exam: _____ Occupation: _____
Family Doctor: _____ If female, are you pregnant or nursing? **Y** ☐ **N** ☐ If pregnant, how many weeks along? ____

How did you hear 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 (once or twice a year) ☐

Eye, Health and Family History:

YOUR EYE HEALTH

Current or previous:

- ☐ Diabetes
- ☐ Glaucoma
- ☐ Corneal Disease
- ☐ Cataracts
- ☐ Retinal Disease
- ☐ Strabismus (eye turn)
- ☐ Peripheral Vision Defects
- ☐ Amblyopia (lazy eye)
- ☐ No problems

FAMILY HISTORY

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

CURRENT VISION

Glasses:

Do you currently wear glasses? **Yes** ☐ **No** ☐ *if yes, answer the questions below; if no, continue to next section:*

What type of lenses are in your glasses? **Single vision** ☐ **Bifocal** ☐ **Trifocal** ☐ **Progressive** ☐

Contact Lenses:

Do you currently wear contact lenses? **Yes** ☐ **No** ☐ *if yes, continue; if no, move 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? **Right** _____ **Left** _____

How old are your current opened contact lenses? ____ **Days / Weeks / Months / Years (number and circle)**

How often do you replace your contact lenses? Check appropriate duration:
Daily ☐ **Weekly** ☐ **2 weeks** ☐ **1 Month** ☐ **3 months** ☐ **Other** _____

What solutions do you use to care for contact lenses?
Renu ☐ **Opti Free** ☐ **Clear Care** ☐ **Boston** ☐ **Biotrue** ☐ **Peroxiclear** ☐
Complete ☐ **Sensitive Eyes** ☐ **Don't Know** ☐ **Other (name)**_____

Have you ever **fainted**? **No** ☐ **Yes** ☐ *if yes, when?* _____

List ***any* eye surgeries** or injuries (or write none): _____

List ***any* medical conditions** you have (or write none): _____

List your **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:

Check off any troubles you are having.

☐ Blurry Distance Vision	☐ Poor night vision	☐ Eye Strain	☐ Glare or reflections	☐ Soreness or pain
☐ Blurry near vision	☐ Headaches	☐ Double Vision	☐ Trouble reading/learning	☐ Light sensitivity
☐ Itchiness	☐ Burning	☐ Watering eyes	☐ Dry eyes	
☐ Floaters	☐ Flashes of light	☐ Gritty feeling	☐ Redness	

Other (**explain**):_____

How many hours do you spend on a device per day? **Average:** _____

How many hours do you spend outdoors per week? **Average:** _____

If you wear contact lenses, are you interested in newer contact lens technology? **Yes** ☐ **No** ☐ **N/A** ☐

If you wear glasses, are you interested in information on thinner/lighter lenses? **Yes** ☐ **No** ☐ **N/A** ☐

Do you want information on LASIK vision surgery? **Yes** ☐ **No** ☐ **N/A** ☐

If you wear glasses or sunglasses, do they filter 100% of UV light? **Yes** ☐ **No** ☐ **Unsure** ☐ **N/A** ☐

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

List your **sporting activities/hobbies** (or write none): _____

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 N/A. Thank you very much. **N/A** ☐

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 or 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.
- **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.

Updated February 2023

PATIENT SIGNATURE: _____ DATE: _____