Patient History /
Assignment of Medical Services Plan Benefits
To Opted Out Practitioner

Trail Vision Care Clinic
Dr. Alf Semenoff, Dr. Nina Pasin, Dr. Lindsay Geeraert

Name (as on care card): _____Birth date (month/day/year): ___/___/___
CARE CARD#:_____Gender:_____Family Doctor: _____
Mailing Address: _____City_____
Postal Code: _____Home phone: _____Cell: _____Business: _____
Email:_____ Occupation/School Grade: _____
Are you allergic to any medications, eye drops, or contact solutions? __yes __no List: _____

Your Medical History:
__yes __no Environment allergy
__yes __no Arthritis
__yes __no Diabetes
__yes __no High blood pressure
__yes __no Heart disease
__yes __no Thyroid
__yes __no Eye injury
__yes __no Eye surgery
__yes __no Cataracts
__yes __no Glaucoma
__yes __no Other:

Family Medical History:

Relationship
__yes __no Blindness_____
__yes __no Cataracts_____
__yes __no Glaucoma_____
__yes __no Macular deg._____
__yes __no Diabetes_____
__yes __no Other:_____

List Of Medications:
_____
_____
_____
_____

Do You Experience?
__yes __no Blurry distance vision
__yes __no Blurry intermediate/computer
__yes __no Blurry close vision
__yes __no Double vision
__yes __no Sudden vision loss
__yes __no Flashes of lights
__yes __no Floating spots
__yes __no Watery eyes
__yes __no Burning eyes
__yes __no Dry eyes
__yes __no Red eyes
__yes __no Frequent headaches
__yes __no Uncomfortable contact lenses
__yes __no Other:

For Contact Lens Wearers:
Are you interested in contact lenses?
__yes __no
Do you currently wear contact lenses?
__yes __no

How often?	**What kind?**
__5-7 days per week	__soft disposable
__1-4 days per week	__soft non-disposable
__< 1 day per week	__hard gas permeable

Brand of Contact Lenses_____
Hours worn per day? _____

Dear Patient:
This form allows the above named practitioner to receive your MSP reimbursement directly for services that are MSP benefits. Your practitioner, by law, must advise you his/her full fee and what portion will be reimbursed by MSP. By agreement, your practitioner may not charge you the portion reimbursable by MSP.

I_____ authorize the Medical Services Plan to pay the above practitioners directly for all reimbursements for benefits payable to me under the Medical and Health Care Services Regulation for care provided to me by said Practitioner. I make this assignment in full knowledge of the amount that I will be personally responsible for and the amount that reimbursable by the Medical Services Plan which will be directed to the above practitioner to be applied against any outstanding monies I owe for the services provide.**MSP Practitioner #: 88417/88120/88689/87478**
MSP Payment#: 88980

BY SIGNING THIS FORM AND FILLING OUT THE EMAIL AND CELL PHONE YOU GIVE TRAIL VISION CARE CLINIC PERMISSION TO SEND YOU NOTIFICATIONS BY EMAIL AND TEXT.

Signature of Patient: _____Date Signed_____

If Minor Please Print Parent/Guardian's Name:_____