MEDICAL HISTORY AND NEEDS FORM

Due to COVID-19, to ensure a safe and efficient visit with **Freelton Eye Care**, we require that you complete and submit this form **within 48 hours *to guarantee*** your appointment**.** We have also implemented a **contactless pay system** for your convenience and safety (Must also complete our *Consent to Fee Collection Form*).

If a question does not apply to you or you are unsure of the answer, indicate "N/A" or "unsure"; DO NOT LEAVE BLANK!

1. PATIENT INFORMATION

Name *(as it appears on your health card)*

_____

Preferred Name _____

Date of Birth (MM/DD/YY) _____

Address:

Apt/House # & Street Name_____

City _____Postal Code _____

Phone (H) _____(C) _____

Email address _____

Do you consent to **Freelton Eye Care** *emailing* to correspond with you regarding your health care, as well as upcoming events and promotions? Yes _____ No _____

For questions regarding anti-spam legislation, go to crtc.gc.ca/eng/com500/faq500.htm

Preferred Method of Contact: Text _____ Call _____ Email _____

OHIP:

HEALTH CARD: #_____ Version Code _____

Expiry Date _____

Primary Insurance Coverage? Yes _____ No _____

Ins. Company Name _____

Card Holder's Name _____ DOB _____

Patient Name _____ DOB _____

Relationship to Card Holder _____

Policy #_____Group # _____

Dependent Coverage Yes _____ No _____

List Name(s) of dependents on plan:

_____Relation? _____ DOB _____

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2. MEDICAL HISTORY and VISUAL NEEDS

Last Eye Exam *(approximate month/year)*

_____

Reason for visit? Any vision changes since your last check-up?

_____

_____

_____

Health Conditions/Medications *(dosage NOT needed)*?

_____

_____

_____

_____

Drug or LATEX Allergies?

_____

Family Doctor?_____ Last Check-up?_____

Eye Conditions, Eye Diseases, or Eye Surgeries?

_____

_____

_____

Currently using Eyedrops (name(s) & how often)?

_____

Eye Diseases that run in your FAMILY? If yes, state disease and relationship of the individual to you.

_____
_____

Do you wear glasses? Yes_____ No_____

If Yes, when? Watching TV_____ Driving_____ Computer_____

Small Print_____ Hobbies_____ For Sun Protection _____ All the time_____

How often are you on the computer?

1-5 hours/week_____ 6-20 hours/week_____ Over 20 hours/week_____

Experiencing eye strain, fatigue, or discomfort? Yes_____ No_____

Rank *in order of importance* the following glasses qualities:

Durability_____ Light-weight_____ Style_____ Blue light protection _____

Do you wear contact lenses? Yes_____ No_____

If Yes, what kind? ***Check all that apply.***

Dailies?_____ Monthlies?_____ Rigid Gas Permeable?_____ Scleral?_____

Overnights?_____ Multifocals?_____

Rate the comfort level of your current contacts on a scale from 1 to 10: _____

Do you plan to order any products at the time of your visit? Yes _____ No _____

If yes, please ***check all that apply:***

Eyeglasses _____ Contact lenses _____ Eyedrops _____ Vitamins _____ Other _____

COVID-19

Do you have a fever, new onset of cough, worsening chronic cough, shortness of breath, or difficulty breathing? Yes _____ No _____

Have you had close contact with anyone with an acute respiratory illness or someone who has travelled outside of the province in the past 14 days? Yes _____ No _____

Do you have a confirmed case of COVID-19 or have you had close contact with a confirmed case? Yes _____ No _____

Have you travelled recently? Yes _____ No _____

If you answered "Yes" to any of these questions, please explain.

_____

_____

If you are NEW to the office, please tell us how you heard about us.

_____

_____

**Please bring your current glasses, sunglasses, and contact lenses to your exam!

By signing this form, you consent to **Freelton Eye Care's** collection of the information above. We collect, use and share your personal information for the following purposes: your ongoing eye care; to provide services to you; to understand your eligibility for benefits and/or services; to arrange payment for services, and as required by law.

The collection of this information is authorized by the *Health Insurance Act*, *Optometry Act*, *Regulated Health Professions Act* and *Health Protection and Promotion Act*.

We will take all reasonable steps to ensure that your personal information is treated confidentially and is only used for the purposes it was collected. We will take all reasonable steps to prevent unauthorized access, use or disclosure of your personal information.

I ,_____, hereby consent to:

- Providing my insurance card information to enable **Freelton Eye Care** to bill directly for my visit and accept payment on your behalf, when applicable.
- Accepting payment receipts and glasses prescriptions via email.
- Providing my personal health information to ensure the time I spend in the office is efficient and focused on my medical care.
- Application of a $100 charge on the officially-booked appointment date if I do not attend my appointment OR cancel with fewer than 48 hours' notice.

I, _____, have read the information on this form and <u>DO CONSENT</u> to the above.

Signature: _____Date: _____