Dr. Fallon Patel and Associates

Optometrists

www.DrPatelOptometrist.com
info@drpateloptometrist.com

First Name: ______________________________

Last Name: ______________________________

Parent/Guardian (*Under 18*): ____________________

Address: ____

City: ______________________________ Postal Code: ______________________

D.O.B. Month: ______ Day: ______ Year: _______

OHIP # : ____________________ VC: _______ Expiry Date: ______________________

Family Physician Name: ____

How did you hear about us? ☐ **Been Here Before** ☐ **Walk in**

☐ **Google** ☐ **Referral Friends & Family**

Contact Information

Home Phone: (   ) __________________________

Cell Phone: (   ) __________________________

Email: _________________________________

Would you like text reminders? **Y or N**

Circle all that apply:

Cataracts

Glaucoma

Diabetes

Other Eye illness_____________

Insurance Provider Information

Insurance: ______________________________

Policy #: ______________________________

ID #: ______________________________

Policy Holder Name: __________________________

Date of Birth: ______________________________

Do you wear contact lenses? **Y or N**

*if yes, which brand do you wear? _________________

Do you experience dryness or irritation with your contact lenses? **Y or N**

Would you like to be fitted with the latest contact lenses? **Y or N**