



**St. Lawrence
optometry**

Dr. Rebecca Chippior

Dr. Brandon Stephens

Dr. Tiffany Nazareth

Dr. Alexander Yowakim

Dr. Samantha Chapman

Date _____ Full Legal Name _____

Preferred Name _____ Assigned Sex at Birth _____ Pronouns _____

Emergency Contact _____ Contact's Phone # _____

Patient Email Address _____ May we contact you via email? Yes No
via text? Yes No

Occupation _____

Hobbies (certain hobbies have unique visual demands) _____

Family Doctor _____ Date of last medical exam _____

Medications (please provide a list to be scanned if possible) _____

Allergies (please include drug and environmental) _____

Are you or could you pregnant/nursing Yes No If pregnant, how many weeks? _____

Are you or were you ever a smoker Yes No Quit If applicable, when did you quit? _____

Reason for seeking an eye examination today _____

When was your last eye exam (please circle) 1 year 2 years 3-5 years 5-10 years 10+ years Never

Do you presently wear glasses Yes No If so, list what type(s) _____

Do you presently wear contact lenses Yes No If so, what brand and type _____

Are you currently under the care of an ophthalmologist? If so, please provide the name _____

Have you ever been diagnosed with an eye disease? Yes No If so, please list _____

Have you ever had surgery on your eyes? Yes No

If yes, please provide details and dates _____

Have you ever had any injuries to your eyes? Yes No

If yes, please provide details and dates _____

Are you interested in contact lenses? Yes No Are you interested in laser vision correction?

Do you have a driver's license? Yes No What class license do you have? _____

Are you required to wear corrective lenses (glasses or contacts) while driving? Yes No

Personal and Family Ocular and General Health History

Condition	Self	Family (list relationship)
Glaucoma	Yes No	
Cataracts	Yes No	
Macular Degeneration	Yes No	
Strabismus ("turned eye")	Yes No	
Amblyopia ("lazy eye")	Yes No	
Other eye diseases (Retinal Detachment)	Yes No	
Diabetes	Yes No	
High Blood Pressure	Yes No	
Thyroid Disease	Yes No	
Arthritis	Yes No	

I am eligible to receive healthcare benefits from the following 3rd party program(s):

Private Insurance WSIB NIHB Veteran Affairs Ontario Works ODSP Other _____

What or who prompted your visit to us today? (Check one)

Friend/Relative Doctor Ophthalmologist Radio Ad Email Ad Internet Search Phone call

Patient Signature _____



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Missed appointments and/or cancellation policy

At St. Lawrence Optometry, we strive to provide excellence in patient-centered eye care and ocular health. Part of that service may mean you are called back for follow-up appointments, most of which we make at the end of your initial visit with us.

If for some reason you are unable to make a booked appointment, whether for a full exam or follow up, we ask that you notify us by phone/email/in person 24 hours in advance of your scheduled appointment time. This policy is in place given the limited availability of appointment spots.

Please note that there is a \$60 missed appointment fee for those that do not comply with this cancellation policy.

I certify that I have been made aware of this policy and agree to maintain my scheduled appointments to the best of my ability. I understand that in certain instances, I may be charged the \$60 missed appointment fee if I fail to give 24 hour notice of missing my appointment.

Patient name _____ Patient signature _____

Date _____ Examining Doctor _____