NEW PATIENT HISTORY FORM

Welcome to our office. Please take a moment to complete this form so we may help care for your health needs. Privacy of personal information is very important to us. We will only use information necessary for the optometric services and products we provide.

[Mr./Mrs./Ms./Miss./Dr.] Last Name: _____ First Name:_____ Middle(I): ____

Address: _____ Apt. # _____

City: _____ Prov: _____ Postal Code: _____

Date of Birth (MM/DD/YYYY) _____ / _____ / _____ Email Address:_____

Preferred contact #: ▢ Home (___)-_____-_____ ▢ Cell (___)-_____-_____ ▢ Work (__)-_____-_____

Occupation: _____ How did you hear about us: _____

Insurance We Direct Bill:

▢ Blue Cross
▢ Blue Cross RCMP
▢ Green Shield
▢ Johnson Inc.
▢ GWL Saudi Arabia
▢ Standard Life
▢ Great West Life (limited plans billable online)
▢ Sun-life (limited plans billable online)
▢ Industrial Alliance
▢ Social Development
▢ Indian Affairs (prior approval required)
▢ Cowan
▢ Desjardins (Only submission on Patients Behalf)
▢ Maximum Benefit or Johnston Group
▢ Chambers of Commerce Group
▢ Manulife Financial

Please show your insurance card to the receptionist when handing in History Form

Name of Last Eye Doctor: _____ Name of Family Physician _____

Approx. Date of Last Exam (MM/YYYY) _____

Reason For Visit:

▢ Regular Eye Exam ▢ Contact Lens Exam/Fit ▢ Lasik Consult ▢ Other _____

Are You Looking/Planning on getting ▢ Glasses or ▢ Contacts ? ▢ Yes ▢ No ▢ Maybe ▢ If Needed

Do you currently wear glasses ? YES / NO Do you wear contact lenses? YES / NO

Are you wearing contact lenses today ? YES / NO What brand do you wear ? _____

Experienced any of the following?:

▢ Frequent Headaches / Migraines
▢ Eye Surgery ▢ Eye Strain
▢ Sudden Loss of Vision
▢ Eye injury
▢ Double Vision
▢ Eyes Been Dilated? Year _____

Ocular/Medical History:

	Self/Family/None		Self/Family/None
Glaucoma:	▢ / ▢ / ▢	Eye Turn	▢ / ▢ / ▢
Macular Degeneration:	▢ / ▢ / ▢	Lazy Eye	▢ / ▢ / ▢
Cataracts:	▢ / ▢ / ▢	Keratoconus	▢ / ▢ / ▢
Retinal Disease:	▢ / ▢ / ▢	Thyroid	▢ / ▢ / ▢
High Blood Pressure:	▢ / ▢ / ▢	Heart Disease	▢ / ▢ / ▢
Diabetes:	▢ / ▢ / ▢	High Cholesterol	▢ / ▢ / ▢
Asthma:	▢ / ▢ / ▢	Cancer	▢ / ▢ / ▢

Other _____

Please list ALL current medications/vitamins :_____

Please list ANY Allergies: _____

Patient/ Guardian Signature _____ **Date (MM/DD/YYYY)** _____