Welcome to **Petrolia Optometry!** Please take a moment to verify and / or update the information below. For privacy reasons, we prefer to not confirm this information out loud in front of others in the waiting area. Thank you!

Patient Name: _____

OHIP Number: _____ **D.O.B** _____

Family Physician: _____

Address:

_____

_____

Home Phone Number: _____ ☐

Alternate Phone Number 1: _____ ☐ } Please check off box next to preferred contact number, and please specify phone type (work, cell, etc):

Alternate Phone Number 2: _____ ☐

Email Address: _____

Alternate Contact (reachable at a different number than the ones listed above):

Contact Name:_____ Relationship: _____

Contact Phone Number: _____

Guardian Information For Child Patients (Please use Full Names):

_____ Relationship: _____

_____ Relationship: _____

PLEASE PRESENT A LIST OF MEDICATIONS TO RECEPTIONIST OR LIST BELOW:

_____

_____

Allergies: _____

For NEW Patients: How did you hear about Petrolia Optometry? ☐ Another Patient (NAME): _____

☐ Internet Search ☐ Family Doctor ☐ Newspaper ☐ Other (Please List): _____

Petrolia Optometry is pleased to announce that we will be offering a new way to contact you in the near future! Please take a moment to fill out the section below:

For appointment reminders, please select any and all methods we may use to contact you:

- ☐ Text Message
- ☐ Email
- ☐ Phone

For Order Updates (For glasses and contact lens orders), please select any and all methods we may use to contact you:

- ☐ Text Message
- ☐ Email
- ☐ Phone

For Patient Recalls (Reminders to see your optometrist), please select any and all methods we may use to contact you:

- ☐ Text Message
- ☐ Email
- ☐ Phone

May we contact you with the following information:

- ☐ Eye Health Education
- ☐ Information about upcoming sales and promotions
- ☐ Newsletters

We need your consent in writing to send any of your personal health information to anyone. Please check off all providers that you give us permission to send information/reports to when required:

- ○ Family Physician
- ○ Another Eye Care Professional (ie. ophthalmologist or optician)
- ○ Medical Specialist (ie. a rheumatologist or internist)
- ○ Nursing Home or Hospital
- ○ Family Member, please list _____

I have read and understand the above information

Please print your full name: _____

Please sign: _____

Date:_____