SEE AND BE SEEN EYECARE PATIENT REGISTRATION

Please complete the information below and submit the form online or if you prefer, print out the form and bring it when you come to our office

Patient Information

Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Home Phone: _____ Daytime Phone: _____ Cell Phone: _____

Email Address: _____

Personal Information

Gender: M F Date of Birth (MM/DD/YYYY) _____/_____/_____

Provincial Health Care Number: _____ VERSION CODE: ____ EXP: _____

Employer: _____

Occupation: _____

How were you referred to our office? Referral (name) _____, Google, Radio, Newsprint

Primary Insurance

Please bring all insurance cards with you to your appointment.

Insurance Company Name: _____

Insurance Company Phone Number: _____

Address : _____

Insured's Name: _____

Identification Number: _____

Group Number: _____

Insured's Date of Birth: _____

Patient's Relation to Insured: _____

Medical History

Who is your primary care physician? _____

When was your last physical exam? _____

Please list all medical conditions (Diabetes, High blood pressure, Arthritis, weight loss/gain, rashes etc.)

_____

Please list all prescription and over-the-counter medications you are currently taking:

_____

Please list any medical conditions that run in your family (Diabetes, High blood pressure)

_____

Please list any drug allergies you have: _____

Ocular History

When was your last eye exam? With whom? _____

Please circle any eye conditions you have (Glaucoma, Cataract, Wandering or Lazy eye, Retinal detachment)
Other: _____

Please check off any current conditions you suffering from

- ☐ Blurred vision
- ☐ Headaches
- ☐ Glare/Light Sensitivity
- ☐ Tired Eyes
- ☐ Amblyopia (lazy eye)
- ☐ Strabismus (crossed eye)
- ☐ Dryness
- ☐ Burning
- ☐ Sandy or Gritty Feeling
- ☐ Foreign Body Sensation
- ☐ Watery Eyes
- ☐ Eye Pain and/or Soreness
- ☐ Redness
- ☐ Haloes
- ☐ Double Vision
- ☐ Floaters or Spots

How many hours a day do you use a computer? _____hrs/day

Glasses & Contact Lens History

How old are your current glasses? _____

- ☐ I am having problems with my current glasses

What brand of contact lenses do you wear? _____

How old are your current lenses? _____

What brand of solution do you soak your lenses in?

_____

- ☐ What is your typical wearing schedule? ____ Hours/day ___ Days/week

Please check off all that apply to you:

- ☐ I am having problems with my current contact lenses
- ☐ There are times when I would rather not be wearing contact lenses
- ☐ I am interested in refractive laser surgery

Signature agreeing to all terms above _____Date _____