

## New Patient Registration

Information provided will be used solely in the provision of your medical eye care.

Legal Name: \_\_\_\_\_ (Optional: Mr.  Ms.  Mrs.  Miss   
(Last name) (First Name)

Address: \_\_\_\_\_ Home Phone: (\_\_\_\_)-\_\_\_\_-\_\_\_\_\_  
\_\_\_\_\_  
City Prov Postal Code Work Phone: (\_\_\_\_)-\_\_\_\_-\_\_\_\_\_  
Email: \_\_\_\_\_ Cell Phone: (\_\_\_\_)-\_\_\_\_-\_\_\_\_\_

Health Care #: \_\_\_\_\_ (\_\_\_\_\_) Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Province (day) (month) (year)

Emergency Contact Name: \_\_\_\_\_ Emerg Phone: (\_\_\_\_)-\_\_\_\_-\_\_\_\_\_

Is this a WCB claim? Yes  No  Claim #: \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Phone \_\_\_\_\_ Optometrist: \_\_\_\_\_ Phone \_\_\_\_\_

Do we have your permission to share our examination findings with your Doctor or Optometrist? Yes  No

Do we have your permission to use data from examination findings for research purposes, with the assurance that no personally identifiable information will be conveyed to any outside party? Yes  No

\*Please note that you may withdraw your consent in writing at any time.

### Medical History:

Existing Eye Conditions or Previous Eye Surgery:

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Existing Medical Conditions or Previous General Surgery:

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Current Medications & Eye Drops:

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Medication Allergies:

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I certify that the above information is complete and correct to the best of my knowledge.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please Note:

If you have a **Routine Eye Examination (ie: your eye problems are not related to a medical problem)** and you are between the ages of 19 and 64, the examination is not covered by Health Care. The fee for this examination is \$100 and will be invoiced at the conclusion of your appointment. This fee is included in the total for a Surgical Vision Correction consultation.

Copy given to patient

Yes  No