



NEW PATIENT INFORMATION FORM

Name: Mr. Mrs. Ms. Dr.

First

Last

Date of birth (MM/DD/YYYY):

AGE:

OHIP #:

Version Code: (last 2 letters)

Home Address:

Postal Code

Home #: ()

Contact #: ()

E-mail:

Occupation:

Do you have school-aged children? Yes No If yes, age(s):

What type of corrective lenses do you use?

Distance Glasses	Reading Glasses	Bifocals	Progressives (Invisible bifocals)
Contact Lenses	None	Previous Laser Surgery	Prescription Sunglasses

Reason for Today's visit:

Routine Check-up	Need glasses	Need contacts	Irritated Eyes
Sudden Vision Loss	Double vision	Flashing Lights / Floaters	Headaches

What year was your last eye exam?

Do you have any of the following medical conditions:

Glaucoma	Cataracts	High Blood Pressure	Diabetes	Arthritis
Thyroid Disease	Lupus	Allergies	Other	

Current Medications:

Family Doctor:

Phone #

Insurance Provider:

Vision Coverage: Yes No Amount:

How did you find out about our clinic:

Internet	Doctor	Phone Book	Hall Poster
Family/Friend	Other		

Do you plan on purchasing eyewear in the next three months? Yes No