DR. SCIBERRAS EYECARE OPTOMETRIST

NEW PATIENT INFORMATION FORM

Name: Mr. Mrs. Ms. Dr.

First Last

Date of birth (MM/DD/YYYY): Month Day Year 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

Email or print out this form and bring a copy to your appointment.

Print Email Form