NORTH YORK EYE CLINIC
NEW PATIENT REGISTRATION FORM

Today's date: , 2023			Optometrist :		
PATIENT INFORMATION					
❑ Mr. ❑ Mrs	❑ Miss ❑ Ms.	Last Name:	First Name:	Middle Name:	
OHIP #:	Version Code:	Birth date: Month / Day / Year / /		Age:	Gender: ❑ M ❑ F ❑ NB
Street address: Unit #:					
City:		Province:	Postal Code:		
Home Telephone #:		Cellphone #:			
E-mail: Would you like your prescriptoiin and receipt sent to you by e-mail? ❑ YES ❑ NO					
Occupation:	Hobbies: [Visual Needs]		Date of last eye examination:		

What is the reason for your visit today?

Blurry Distance Vision	Double Vision	Redness of Eyes	Headaches
Blurry Near Vision	Flashes of Light	Itchy Eyes	Stye
Blurry Computer Vision	Floaters	Burning Eyes	Eye Infection

Other: _____

Do you or do any of your family members have any of the following ocular conditions?

Cataracts Retinal Detachment Retinitis Pigmentosa Colour Blindness Strabismus
Amblyopia Glaucoma Macular Degeneration
Other: _____

Please state your family member and the type of ocular condition that they have:

Do you drive ? ❑ YES ❑ NO	Does your driver's license state that you must wear corrective lenses to drive? ❑ YES ❑ NO
Do you wear glasses?	Age of your eyeglasses?

Do you wear sunglasses? ❑ YES ❑ NO	Are you satisfied with your frames and lenses? ❑ YES ❑ NO If not, why?_____
Do you wear contact lenses? ❑ YES ❑ NO	What brand of contact lenses do you wear? _____
Do you have any problems with your current contact lenses? ❑ YES ❑ NO	How often do you wear contact lenses? _____
Do you use any eye drops? ❑ YES ❑ NO	Please list any eye drops used: _____

Do you require a contact lens prescription? ❑ YES ❑ NO *Extra charges may apply*	Do you require a Contact Lens Evaluation? Evaluation of fit, vision and complications due to contact lens use. ❑ YES ❑ NO There is an additional charge of $50 for this test.
Would you like to have your pupils dilated today? An eyedrop is instilled in your eyes to widen the pupils. This enables the doctor to better evaluate your peripheral retina and internal ocular structures. ❑ YES ❑ NO	Would you like to have your retinas digitally photographed today? ❑ YES ❑ NO *This test further helps the eye doctor to examine the structures inside your eyes for the presence of eye diseases. There is an additional charge of $55 for this test.*

MEDICAL INFORMATION	
Do you have any of the following medical conditions? Diabetes Hypertension High cholesterol Depression Anxiety Arthritis Hypothyroid Hyperthyroid Lung Disease Heart Disease Cancer Other: _____	
Medications:	
Allergies:	
Are you pregnant? ❑ YES ❑ NO	Are you breastfeeding? ❑ YES ❑ NO

INSURANCE INFORMATION			
Name of Insurance Provider:	Relationship to Insured member:	Policy Number:	Plan member Number:
The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the clinic. I understand that I am financially responsible for any balance. I also authorize the clinic to process the claim on my behalf. _____ *Patient signature* _____ *Date*			